Pierce County Accountable Community of Health

Medicaid Transformation Project Plan Submission

NOVEMBER 16, 2017

PIERCE COUNTY ACH

2201 S 19th St, #101 Tacoma, WA 98405

Acknowledgements

PCACH would like to acknowledge the vision of and the hundreds and hundreds of hours of work by the Pierce County community:

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Section I: ACH-Level

Regional Health Needs Inventory

Project Selection and Planning

From its inception, PCACH has focused on data-informed decision making. As part of our commitment, we established a Data and Learning Team (DLT), which is responsible for developing data capacity and strategies to ensure that PCACH and its partners can effectively achieve shared goals. The DLT supports ACH needs assessment, Regional Health Improvement Planning, program implementation, self-monitoring, reporting, and evaluation efforts, and is made up of representatives from managed care organizations (MCOs), health systems, FQHCs, Independent Practice Associations (IPAs), the Washington Healthcare Authority (HCA), and community-based organizations (CBOs). As part of its work, the DLT reviewed Regional Health Needs Inventory (RHNI) data to identify priorities, made recommendations for target populations, and discussed regional process and outcomes measures.

The Role of Our Governing Structure: Although the DLT is the hub of our data review and translation, it also serves as a liaison to our key governing bodies by presenting and translating data, so it can be used to make recommendations and drive decision making. Several key governing groups, including the Regional Health Improvement Plan Council (RHIP), the Community Voices Council (CVC), and Provider Integration Panel (PIP), also played a role in reviewing RHNI data to identify potential gaps and disparities. Their feedback was used to identify and prioritize additional data sources we needed to round out our process. Together, we developed criteria for priority population decision making to ensure consistency and alignment across our stakeholder feedback.

Table 1. Priority Population Criteria Tool

Criteria	Pregnant Women	Women with BH Dx	Recently Incarcerated	BH & Chronic Condition Dx	Chronic Condition Dx
Need					
Does the priority population disproportionately experience poor health outcomes?					
Are there subgroups within the population that experience disparities?					
Is there a gap in existing services to effectively address these outcomes?					
Impact					
Is there strong potential for the project/intervention to improve outcomes for the priority population in 2-3 years?					
Is the priority population large enough for improvements to drive community-wide outcomes?					
Data Feasibility					
Do data currently exist to explore the priority population, track outcomes, and evaluate impact?					

These Governing Body groups, along with the PCACH Board, reviewed and discussed toolkit measures by project, including potential earnings, alignment across toolkit projects and statewide and regional performance measurement efforts, current state of metrics performance (based on existing, publicly available data), and estimates of proxy improvement targets and the effort/difficulty in meeting targets.

Alignment with MCOs: In addition to the ACH's governing bodies, we have had extensive data

conversations with managed care organizations (MCOs) in our region to ensure alignment around a regional data strategy. Our aim was to identify key crossover areas between ACHs and MCOs under the Demonstration. As an ACH, we aim to develop a strategy for our portfolio of projects, support for providers/Domain 1 strategies, and design monitoring and quality improvement systems that complement and align with existing MCO activities and goals. Our discussion generally covered, but was not limited to, the following topics:

- *Members/Population Overview*: What is the makeup of your member population in Washington? Are there key population health strategies underway relevant to this population and ACH Demonstration work?

- *Support for Providers*: How can the ACH complement the work of the MCO in regard to supporting providers through the Demonstration and the transition to VBP?

- *Measurement/Quality Improvement*: Is there alignment in ACH Demonstration measures and MCO key metrics of interest with providers? What kind of data and quality improvement support do you provide your contracted providers?

- PCP Assignment/Empanelment: How are members assigned to primary care providers? Is there an algorithm for assignment? How often does provider assignment change? To what extent are members seeing their assigned providers versus non-assigned providers? How are providers notified when they are assigned members, how are members notified?

Data-Informed Approach: PCACH employed a multi-pronged strategy for using data to inform project selection and planning. We began with a review of the RHNI starter kit from HCA, then built upon that starting point with data from existing regional assessment efforts such as Public Health's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) and the Community Health Needs Assessments (CHNAs) completed by area hospitals. Where more specific data was needed, we filled in gaps by working with MCOs, health systems, provider groups, and community-based organizations.

The local public health department was one of our best resources for identifying data gaps. The Tacoma-Pierce County Public Health Department provided data on teen birthrates, low birth weight, and infant deaths by zip code to fill gaps in data needed for Pathways target population setting, data on opioid deaths to aid in developing our partner goals and requirements for the opioid strategy, and county jail data (from previous local public health collaborations with the county jail) to aid in target population analysis for diversion and other project areas.

The DLT also leveraged the HCA Historical Data file for toolkit measures, draft methodology from HCA, NCQA Medicaid 90th percentile benchmarks, and PCACH-developed proxy improvement targets for pay-for-performance measures to help estimate the number of events or individuals that needed to be counted for a measure to reach those targets. This proxy information is being used by PCACH committees and work groups to select target populations and refine project approaches and strategies. Finally, we fielded a short online survey to acquire stakeholder input regarding which populations to prioritize.

The DLT reviewed available data to identify potential priority populations and recommended two main populations based on the criteria of need, impact, and feasibility: pregnant women and individuals with co-occurring diagnoses of behavioral health and chronic conditions. The DLT also recommended

subpopulations and measures of interest to track. The recommendations were shared with the RHIP, PIP, CVC, and the board members, who provided feedback and review.

Figure 1. Regional Target Population Prioritization Survey Results

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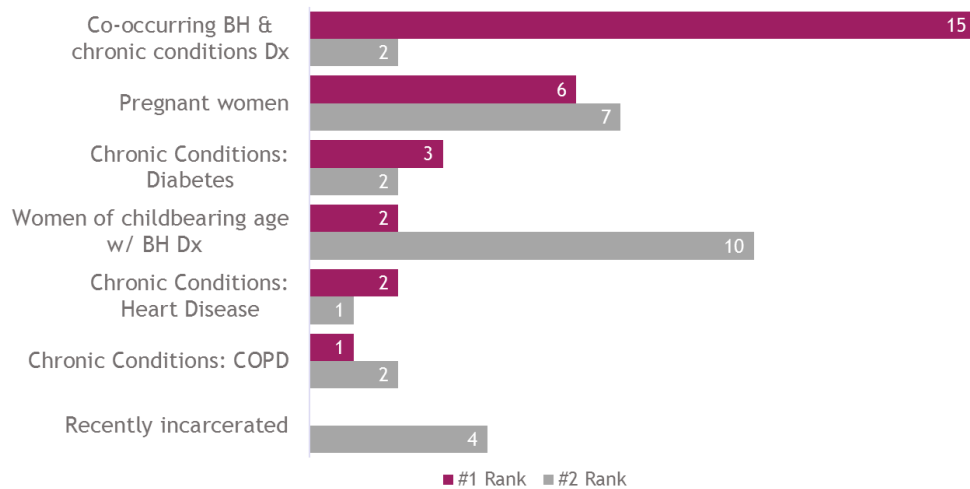
Data Sources

In total, PCACH used more than twenty different data sources, many of which are quite comprehensive and contains measures for multiple key domains. They were used in nine different applications – with many sources filling cross-cutting purposes for PCACH decision making needs. Table 2 below exhibits the wide array of data that PCACH has either acquired or leveraged to inform its decision making.

Table 2. Pierce County ACH Data Sources and Uses

Data Source	RHNI and assessment	Project selection	Identifying key partners	Target population selection	Population exploration	Workforce capacity assessment	Project planning and design	Stakeholder engagement	Regional funds flow design		
ACH Partner Inventories	✓	✓	✓	✓		✓	✓	✓	✓		
Aggregate data from MCOs and delivery system partners		✓	✓	✓			✓	✓	✓		
BRFSS data (via TPCHD)	✓	✓		✓							
CHARS data (via Tacoma-Pierce County Health Dept)		✓					✓				
Community Checkup	✓										
DOH PRAMS, birth, and abortion data	✓	✓			✓						
DSHS ACH Profiles	✓	✓		✓	✓	✓					
HCA AIM provider report	✓		✓	✓				✓	✓		
HCA Historical Data	✓	✓	✓	✓	✓	✓	✓	✓	✓		
HCA Medicaid enrollment reports	✓	✓	✓	✓	✓	✓	✓	✓	✓		
HCA RHNI "Starter Kit"	✓	✓		✓	✓						
HCA/RDA measure decomposition	✓		✓	✓							
Healthier Washington Dashboard	✓	✓		✓	✓				✓		
Pierce County Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)	✓	✓	✓	✓							
Pierce County jail data (via TPCHD)	✓	✓		✓							
Regional Hospital Community Health Needs Assessments (CHNA)	✓	✓						✓			
RWJF County Health Rankings	✓	✓			✓	✓					
UW Center for Health Workforce Studies reports			✓			✓					
WA Dental Foundation dental measures	✓	✓			✓						
WA First Steps Database	✓	✓		✓							
WA Healthy Youth Survey	✓	✓			✓						

Health Needs Relevant to MTP

Pierce County is the second most-populous county in Washington State, with an estimated 2017 population of 859,400. It is a largely urban and suburban county, though the eastern part of the county is far less populous than the area around Tacoma.[1] Pierce County's largest city - and the third largest city in the state is Tacoma, with an estimated 2017 population of 208,100.

Population Profile

In 2016, Pierce County served nearly 228,000 Medicaid enrollees; this represents 12 percent of Washington's Medicaid population and 27 percent of the total Pierce County population. The region has higher rates of unemployment and poverty than the state average, and lower median income despite an

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[1] WA State Dept. of Health, Rural and Urban Commuting Areas

inflated cost of living. Medicaid members in the region have a greater likelihood of experiencing homelessness, with Hispanic and Black individuals more likely to be without housing.[2] Pierce County experiences higher obesity and smoking rates than the state average.

Pierce County had existing efforts through regional assessment efforts by hospitals and the local health jurisdictions to outline top community priorities, identifying access to care, mental health, tobacco use, obesity, behavioral health and cultural competency.[3] Pierce County Community Health Improvement Plan priorities included mental health, chronic disease prevention, and access to quality healthcare and preventive services.[4] Many of these assessments garnered community-identified needs as well.

In strong alignment with existing assessments, the following are PCACH-identified challenges and needs:

Behavioral health, **including mental health and substance use treatment**: The use of opiates climbed through 2015, and treatment admissions for opiates have greatly increased, particularly related to heroin use. Adults and teens in Pierce County reported more days of poor mental health and feelings of hopelessness than those in the state overall.[5]

Reproductive, maternal, and child health: Teen and unintended pregnancy rates are higher than the state average, while lower percentages of Medicaid-enrolled women use long-acting reversible contraception.

Diabetes: While the region has average diabetes diagnosis rates, people with diabetes in Pierce County are less likely to receive recommended annual treatment such as blood sugar testing and eye exams.[6]

Access to care: Parts of Pierce County are designated as primary care health professional shortage areas.[7] Among ACHs, this region ranks lowest for the percent of Medicaid members who have a substance use disorder diagnosis and receive treatment.[8] Hispanic and Black patients are less likely to receive follow-up care after an emergency department (ED) visit related to alcohol or drug dependence.

Mental health status: Adults in Pierce are more likely than adults statewide to report poor mental health in the last 30 days (14.3 percent v. 11.3 percent). American Indian/Alaskan Native (29.8 percent) and low-income adults (25.9 percent) in Pierce County are more likely to report poor mental health in the last 30 days.

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[2] DSHS ACH Measure Decomposition: Homelessness, Broad Definition.

[3] TPCHD CHIP: http://www.tpchd.org/about/community-health-improvement-plan/; MultiCare CHNA: https://www.multicare.org/community-health-needs-assessment.

[4] Pierce County CHIP: http://www.tpchd.org/about/community-health-improvement-plan/

[5] BRFSS and Healthy Youth Survey.

[6] Healthier Washington Data Dashboard: Diabetes Diagnosis, Diabetes Eye Exam, and Diabetes HBA1c Testing Measures.

[7] DOH Primary Care Shortage Areas Map: ftp://ftp.doh.wa.gov/geodata/layers/maps//primary.pdf.

[8] DSHS Cross System Outcomes Measures: https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0.

Figure 2. Adult Mental Health Status

Percent of adults reporting poor mental health in the past 30 days (BRFSS, 2013-2015)
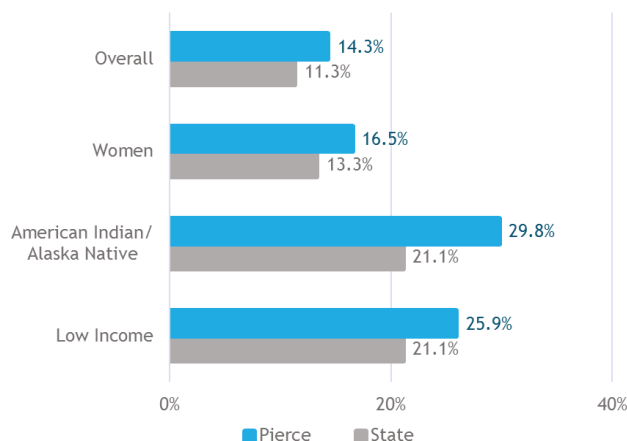
Housing and housing affordability: Housing and housing affordability are key issues in Pierce County. More than 40 percent of residents spend 30 percent or more of their income on housing, compared to 37 percent statewide.[9] As of 2017 point-in-time count, Pierce had at least 1,300 unhoused residents. [10]

Poverty: The region has a similar poverty rate to the state average (12.2 percent and 12.4 percent, respectively), though the county's median household income of $60,168 lags behind the state average of $64,680.[11] Pierce has higher unemployment than the state: 6.3 percent vs. 5.6 percent in 2016, though the August 2017 rate has improved to 5 percent in Pierce, compared to 4.5 percent statewide.[12] More than 25 percent of employed Pierce County residents travel to neighboring King County for work.[13]

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[9] HCA RHNI Starter Kit data.
https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433

[10] https://www.co.pierce.wa.us/4719/Point-In-Time-Count-PIT

[11] HCA RHNI Starter Kit data.

[12] Economic Security Department, Labor Summaries: https://esd.wa.gov/labormarketinfo/labor-area-summaries

[13] Economic Security Department, County Profile: https://esd.wa.gov/labormarketinfo/county-profiles/pierce

Figure 3. Social and Environmental Determinants of Health

Percent of people living in poverty

Pierce	12.4%
State	12.2%

0% 10% 20%

Median household income

Pierce	
State	

$0 $35,000 $70,000

Unemployment

Pierce	5.7%
State	5.0%

0% 5% 10%

Unaffordable housing

Pierce	40.5%
State	37.1%

0% 20% 40% 60%

Data Source: HCA RHNI Starter Kit
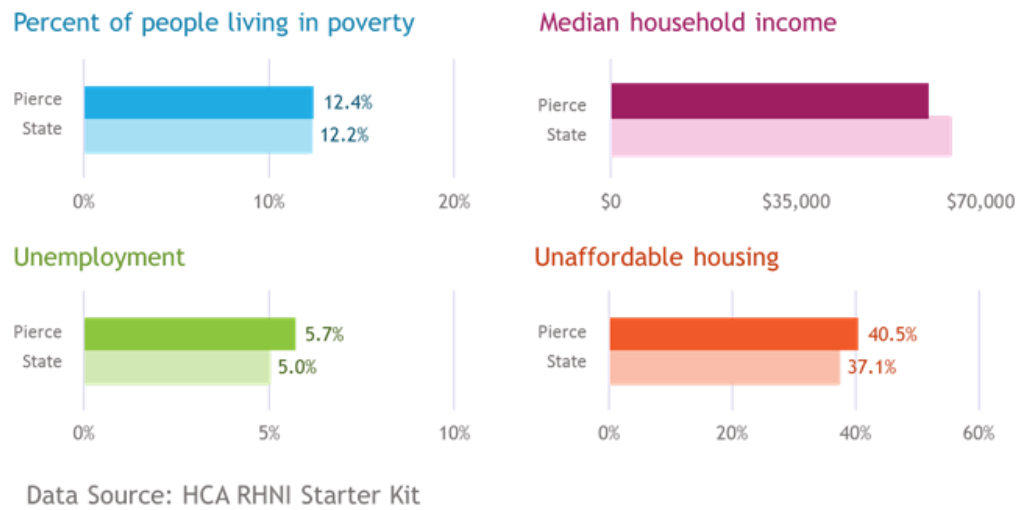
Medicaid Beneficiary Population Profile

Pierce County has 230,000 Medicaid enrollees, about 12 percent of statewide Medicaid enrollment. The region mirrors the state Medicaid demographics with a couple exceptions. Pierce County has a higher percentage of Black residents (12 percent) than the statewide (7 percent) and fewer people identify as Hispanic (15 percent), compared to statewide (21 percent).

Table 3. Pierce County Medicaid Demographics

	Pierce		WA State	
	#	%	#	%
Overall	230,407	12%	1,909,374	100%
Gender				
Male	106,511	46%	906,276	46%
Female	123,896	54%	1,003,096	53%
Race/Ethnicity				
American Indian/Alaska Native	33,651	3%	55,036	3%
Asian	10,731	5%	86,617	5%
Black	28,507	12%	137,185	7%
Native Hawaiian/ Pacific Islander	11,815	5%	55,840	3%
White	123,492	54%	1,081,023	57%
Multiracial	5,003	2%	24,503	1%
Other	23,098	10%	278,007	15%
Unknown	21,427	9%	191,163	10%
Ethnicity				
Hispanic	33,651	15%	405,445	21%
Not Hispanic	154,610	67%	1,148,252	60%
Unknown	42,146	18%	355,677	19%
Age				
Adult (19+)	125,193	54%	1,035,130	54%
Child (<19)	105,214	46%	874,244	46%
Language*				
English	202,669	89%	1,588,222	84%
Spanish	10,739	5%	172,807	9%
Other	4,071	2%	49,201	3%
Unknown	10,434	5%	82,466	4%

In 2016, 5.8 percent of Medicaid enrollees in Pierce County experienced homelessness, which is higher than the statewide average (5.0 percent).[14] That same year, just over half (51.8 percent) of Medicaid adults were employed, similar to the statewide rate of 51.7 percent.[15] More than 6 percent of Medicaid enrollees were arrested in 2016.[16] Of all inmates booked to the Pierce County jail, 38.9 percent (4,217 inmates) were enrolled in Medicaid upon booking.

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[14] HCA ACH Toolkit Historical Data: https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036

[15] DSHS Cross-system Outcomes Measures: https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0

[16] HCA ACH Toolkit Historical Data: https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/36950052036
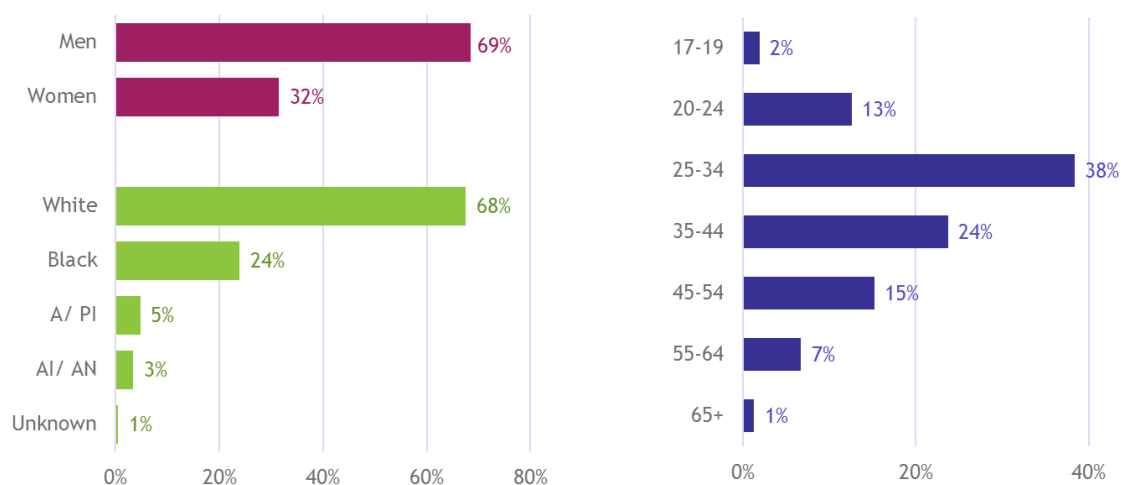
While all of HCA's contracted managed care plans are represented in Pierce County, most area Medicaid beneficiaries are enrolled in Molina Healthcare of Washington (44.4 percent).[17]

Figure 5. Pierce County Medicaid Enrollment by MCO

Pierce County Medicaid Enrollees, May 2017
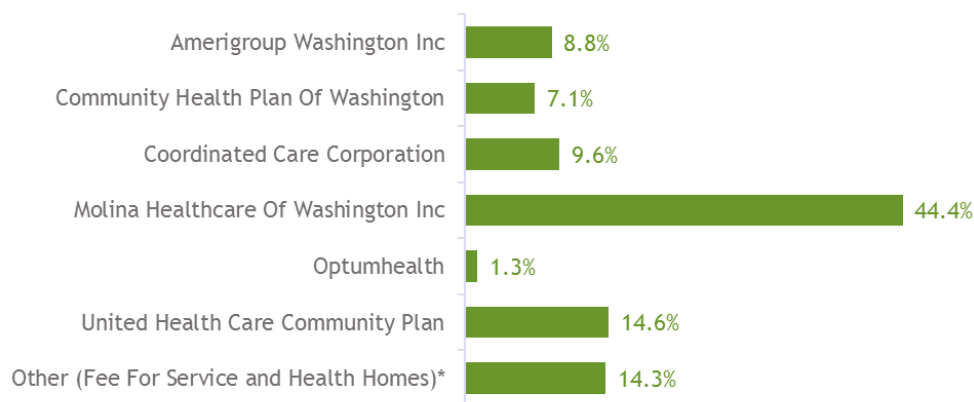
Health Status

Mental Health

Nearly 61,000 Medicaid enrollees in Pierce County have been diagnosed with mental illness. This

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[17] DSHS Cross-System Outcomes Measures, Medicaid clients enrolled with Managed Care Organizations: https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0

represents 28.4 percent of enrollees in Pierce, compared with 27.1 percent statewide.[18] In Pierce County, 27.9 percent of acute non-pregnancy and child birth hospitalizations are for mental or behavioral health diagnoses. This is higher than the statewide average of 18.2 percent.

Figure 6. Pierce County Medicaid – Mental Health Diagnoses
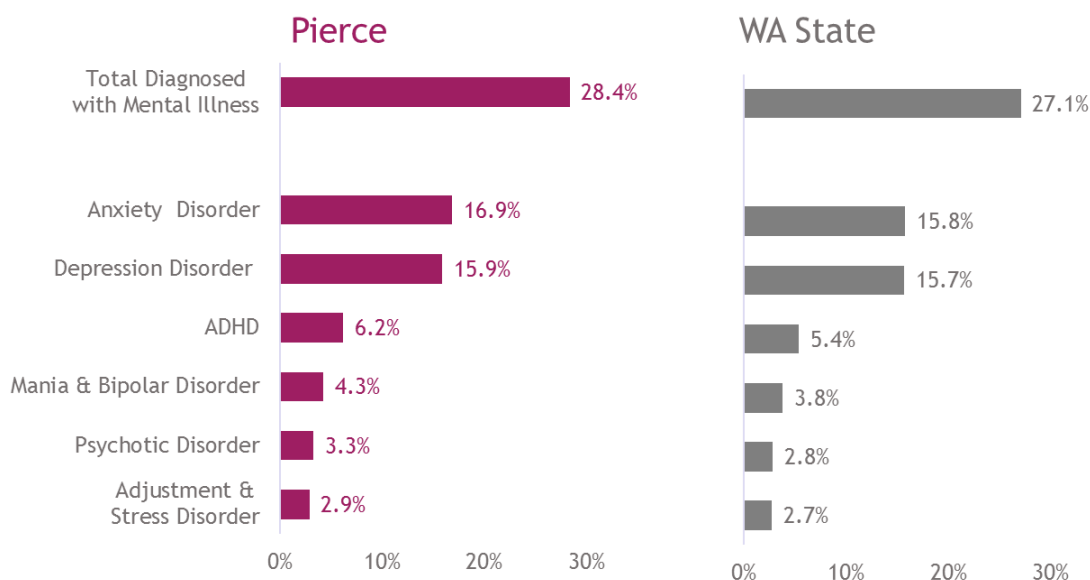
Chronic Disease

Nearly 14,000 (7.2 percent) of enrollees have a dual diagnosis of mental illness and substance use disorder. The rate for AI/AN enrollees is 13.4 percent; for NH/PI it is 3.2 percent. Adults ages 30-59 are more likely to have dual diagnoses. More than 50,000 (about 27 percent) Medicaid enrollees in Pierce County have been diagnosed with at least one chronic condition.[19] Noteworthy chronic disease prevalence disparities exist for specific race/ethnicity groups for Medicaid beneficiaries in Pierce County. Among whites, 25.3 percent have at least one chronic condition, compared with 31.4 percent of Native Hawaiian/Pacific Islanders, 30 percent of Hispanics, and 29.7 percent of Asians.[20]

More than 41,426 (21.7 percent) of enrollees have co-occurring chronic conditions and behavioral health diagnoses. Native Hawaiian/ Pacific Islander have the lowest rates (11.8 percent) and American Indian/Alaskan Natives (32 percent) and whites (25.9 percent) have the highest rates.

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[18] DSHS ACH Profiles, Pierce County: https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

[19] HCA BH and Chronic Conditions data

[20] HCA BH and Chronic Conditions data

Figure 7. Chronic Condition Diagnoses
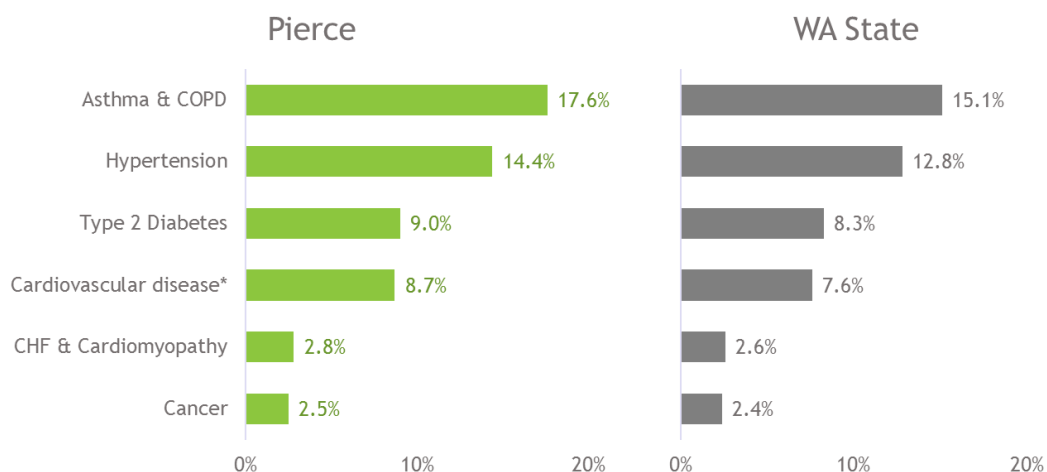
Substance Use Disorder

In 2016, there were 21,841 Medicaid enrollees who had a diagnosis related to alcohol or substance use.[21] Of those, 6,558 have a diagnosis history of opioid abuse or dependence. There are 34,517 Medicaid enrollees that have at least one opioid prescription, 30,293 (88 percent) of whom have no history of cancer diagnosis. Of prescription opioid users without a history of cancer diagnosis, 20 percent have high dose prescriptions and 18 percent have prescriptions for 30 days. [22]

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[21] DSHS ACH Profiles, Pierce County: https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

[22] HCA RHNI Starter Kit data

Figure 8. Pierce County Opioid Use

In Pierce County, there are **1,297** providers prescribing opioids and **34,517** Medicaid opioid users, defined as Medicaid members with at least one opioid prescription.

Age Group	Percent
Ages 0-9	1%
Ages 10-19	8%
Ages 20-29	21%
Ages 30-39	24%
Ages 40-49	15%
Ages 50-59	16%
Ages 60-69	6%
Ages 70-79	
Ages 80+	

Sex	Percent
Female	65%
Male	35%

Race/Ethnicity	Percent
White, Non Hispanic	60%
Black, Non Hispanic	14%
Other/UNK	12%
Hispanic	10%
AI/AN, Non Hispanic	3%
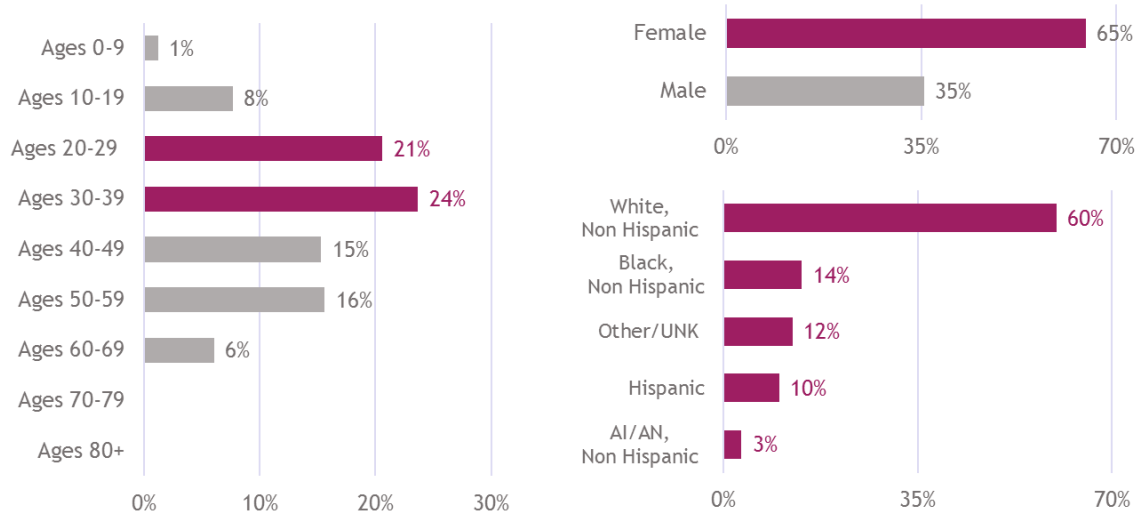
Health Care Providers

Physicians

Pierce County has 216 physicians per 100,000 population, and 72 primary care physicians per 100,000 population. This is slightly below the state average of 229 physicians and 81 primary care physicians per 100,000 population.[23] There are 1,279 providers prescribing opioids in the region.[24]

Hospitals

There are no Critical Access Hospitals in Pierce County. Western State Hospital is one of two state-run inpatient psychiatric facilities and serves counties on the western side of the state. St. Joseph Medical Center has a 23-bed inpatient psychiatric unit. There is also a 16-bed mental health crisis facility, Recovery Response Center, in Fife, WA.

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[23] Washington Center for Health Workforce Studies, 2016 WA State Physician's Workforce

[24] HCA RHNI Starter Kit data

Table 4. Pierce County Hospital Locations and Size[25]

Hospital	Location	Size (# of beds)
MultiCare Tacoma General	Tacoma	437
MultiCare Mary Bridge Children's Hospital	Tacoma	82
MultiCare Good Samaritan	Puyallup	286
MultiCare Allenmore	Tacoma	130
St. Anthony Hospital (CHI Franciscan)	Gig Harbor	113
St. Clare Hospital (CHI Franciscan)	Lakewood	106
St. Joseph Medical Center (CHI Franciscan)	Tacoma	366
Western State Hospital	Lakewood	800+
Madigan Army Medical Center	Tacoma	240

Healthcare Partners

The following is a list and description of the key healthcare partners servicing Medicaid in Pierce County:

1) **MultiCare** is a large health system in the region, operating 26 primary care clinics, 59 specialty care clinics, 10 urgent care centers, and four hospitals. Twenty-six percent of MultiCare patients are Medicaid enrollees. Of emergency department and inpatient patients, 35 percent and 30 percent are Medicaid enrollees, respectively.[26]

2) **Catholic Health Initiatives (CHI) Franciscan** operates three hospitals in Pierce County, along with 77 outpatient primary care, 16 prompt care and 61 specialty clinics.

3) **Sea Mar** operates federally qualified health centers (FQHCs) in Pierce County. Sea Mar operates 10 primary care, dental, and behavioral health clinics in Pierce County and serves almost 24,000 Medicaid enrollees (about 67 percent of their patients). [27]

4) **Community Healthcare (CHC)** is another FQHC organization that operates five medical clinics and three dental clinics in Pierce County. In 2016, CHC served more than 44,000 patients, 71 percent of which were enrolled in Medicaid.[28]

5) **Greater Lakes Mental Healthcare** operates seven outpatient mental health and substance use disorder treatment facilities and serves 9,600 patients in Pierce County, 85 percent of which are

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[25] Washington State Hospital Association: http://www.wsha.org/our-members/member-listing/

[26] Pierce ACH partner inventory

[27] Pierce ACH partner inventory

[28] Community Health Care 2016 Annual Report: https://www.commhealth.org/about-us/annual-reports/

enrolled in Medicaid.[29]

6) **HopeSparks** provides behavioral health services to children and families. They operate four clinics in the region, serving 3,300 Medicaid enrollees, who make up about 64 percent of their clients.[30]

7) **Northwest Physicians Network** is an IPA serving 6,400 Medicaid enrollees (about 30 percent of their patients).

8) **Pediatrics Northwest** is a pediatric IPA with three clinics in Pierce County. About 46 percent of their patients are enrolled in Medicaid.

9) **Comprehensive Life Resources** provides behavioral health services, housing, and foster care services to 5,500-6,000 Medicaid enrollees. Seventy percent or more are adults, 6-8 percent are children. Ninety percent have serious mental illness.

10) **Prosperity Wellness** provides behavioral health services for 2,300 Medicaid enrollees annually.

11) **Tacoma-Pierce County Health Department** provides behavioral health, parenting services, care coordination/case management, immunizations, STD/HIV screening and treatment, oral health varnishes and sealants. TPCHD serves 1,200 Medicaid enrollees through its methadone clinic, 1,500 through its immunization clinics.

12) **Planned Parenthood of the Greater Northwest** provided services for 4,298 women and 356 men in 2016. Eighty-five percent of these patients were Medicaid enrollees. Services are delivered through two community health centers and in partnership with schools and community-based organizations.

13) **Northwest Integrated Health** (Hub and Spoke Grantee) provides fully-integrated primary and behavioral health services for 1,500 Medicaid enrollees through three clinics and several partnering spoke agencies.

Community-Based Resources

Pierce County has an array of critical community organizations that provider resources vital to the health and wellbeing of the Medicaid population – including housing, food assistance, financial counseling, employment assistance, and other family support. These services are also available from culturally appropriate organization – which will be key partners to include, especially for project areas where disparities among these population exist.

Housing

Pierce County Housing Authority and Tacoma Housing Authority offer housing and rental assistance.

Pierce County has more than a dozen emergency and transitional housing shelters, including two specifically for women and families leaving domestic violence situations.[31]

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[29] Pierce ACH partner inventory and www.glmhc.org/about/

[30] Pierce ACH partner inventory

[31] https://www.co.pierce.wa.us/430/Emergency-Shelters

Food Assistance

The region has more than 50 food banks. While the majority of services are in or around Tacoma, there are a number of food banks in less urban areas of the county.

Culturally-Appropriate Services

Many organizations provide culturally-appropriate services to specific populations:

- Korean Women's Association: provides multicultural services to marginalized groups
- Centro Latino: serves the Latino community
- Tacoma Urban League: supports African Americans and other ethnic minorities
- Oasis Center: provides services to LGBTQA youth
- Rainbow Center: serves the LGBTQA community
- Samoan Nurses Organization of WA: provides health education and resource referral with a focus on chronic disease management and prevention.

EMS, Fire and Rescue

The county has multiple providers of emergency medical services (EMS), fire and rescue services, including:

- Central Pierce Fire and Rescue
- City of Tacoma Fire Department
- East Pierce Fire and Rescue
- West Pierce Fire and Rescue

Family Support

The county also has an assortment of services that provide support to families including:

- Children's Home Society of Washington provides child welfare, family support, foster care, behavioral health, and early childhood services. Perinatal Collaborative of Pierce County is a network of 65 community-based agencies that touch the lives of mothers and children, primarily through care coordination or as referral agencies.
- Catholic Community Services offers an array of housing, food, youth and family, and behavioral health services.
- Sound Outreach provides financial assistance and counseling, employment coaching, and housing services for 3,000 Medicaid enrollees.
- Point Defiance AIDS Project provides needle exchange and harm reduction services.

Level of Access or Connection to Care

Primary Care

Though services exist, it is important to understand the rate in which populations are able to access those services. In Pierce County, child access to primary care is higher than state average, with 89

percent of children enrolled in Medicaid having visited a primary care provider in the past year. Native Hawaiian/Pacific Islander children were least likely to see a primary care provider (83 percent).[32] Adult access to primary care is lower than children, with 75 percent of adult Medicaid enrollees having visited with a primary care provider in the past year. Men (65 percent) were less likely than women (82 percent) to have visited their primary care provider.[33]

Emergency Department Use

Pierce County's rate of Emergency Department Utilization is 52 per 1,000-member months (MM) for Medicaid enrollees. Racial disparities exist in ED use; the rate for Black enrollees is 69 per 1,000 MM, while the rate for Asian enrollees is 23 per 1,000 MM. Women are more likely than men to have an ED visit (58 and 45 per 1,000 MM, respectively).[34] Adults with co-occurring MH and SUD diagnoses are more than four times as likely to have three or more ED visits in a year. Adults with diabetes are more than five times as likely to have three-or-more ED visits in a year.[35] Pierce County's rate of potentially avoidable ED visits is on par with the state average (17 percent).

Capacity and Access Gaps

Barriers to care

Community members have expressed the need for more culturally competent care. Suggestions include community health workers, partnering with community agencies that understand diverse cultures and languages, medical translators, and providers serving LGBTQ populations. Community members have also identified transportation as a barrier to care, particularly for patients who live in rural areas.[36]

Capacity or Access Gaps

Pierce County is designated as a medically underserved area for primary care.[37] Areas in east Pierce County, particularly Eatonville/Roy, have been federally designated as a geographic Health Professional Shortage Area (HPSA) for primary care.[38, 39] Parts of Pierce County, particularly in East Pierce, are located more than a 30-minute drive from an acute care hospital.[40] Pierce County also has high rates of

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[32] Healthier Washington Dashboard

[33] Healthier Washington Dashboard

[34] Healthier Washington Dashboard

[35] DSHS RDA Measure Decomposition

[36] Tacoma General and St. Joseph Community Health Needs Assessments

[37] WA State Dept. of Health: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/MedicallyUnderservedAreaDesignations

[38] HRSA Data Warehouse: https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFind.aspx

[39] WA State Dept. of Health, Primary Care Shortage Areas

[40] WA State Dept. of Health, 30 minute drive times from acute care hospitals: www.doh.wa.gov/DataandStatisticalReports/DataSystems/GeographicInformationSystem/HardcopyMaps

potentially preventable hospitalizations. In 2013-2015, legislative districts comprising Tacoma, Lakewood, and Spanaway had the highest rates of preventable hospitalizations in the state. The 29th district had 1,299 potentially preventable hospitalizations per 100,000 persons—about double the state average. This suggests that there are primary care access and utilization issues. Patients in the region may not have access to the care they need to manage chronic conditions like asthma or diabetes.[41]

Behavioral Health: Pierce County experiences gaps in capacity and access to behavioral healthcare. The region is below the state average for Mental Health Treatment and Substance Use Treatment Penetration, which are measures that look at the percentage of Medicaid enrollees with a service need (such as a mental health diagnosis) who received services.[42] In 2015, only 40.8 percent of Pierce County Medicaid enrollees with a mental health diagnoses received a service related to that diagnoses. This is lower than state average of 42.9 percent. Similarly, in 2015 only 21.4 percent Pierce Medicaid beneficiaries with an SUD diagnosis received related care, again lower than the state average of 26.7 percent. Pierce is the lowest performing region in the whole state for both mental health and SUD treatment penetration. This is considerably concerning given the high rates of diagnoses in these areas. There are an estimated 2,137 opioid injectors in Pierce County. Of those, 77 percent reported that they wanted to reduce or stop using, and 22 percent reported experiencing an overdose in the year prior.[43] Of the 6,500 Medicaid enrollees with a diagnosis history of opioid abuse or dependence, 10 percent have received Medication Assisted Treatment (MAT) with buprenorphine and 15 percent have received MAT with methadone. This suggests a gap in access to MAT. [44]

Psychiatric Care: The region has identified a shortage for inpatient psychiatric care. Pierce County currently has just 2.3 beds per 100,000 population, compared to the national average of 26 beds per 100,000 population – one of the worst regions in the nation for access to psychiatric inpatient care.[45] Pierce County Pierce County government, CHI Franciscan, and MultiCare are partnering to build a new psychiatric inpatient facility, which will have 120 beds.[46] The region is also planning to build a mental health crisis and respite center.

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[41] Office of Financial Management; Potentially Preventable Hospitalizations by Legislative District, July 2017

[42] HCA Data Product: ACH Toolkit Historical Data

[43] UW Alcohol & Drug Abuse Institute; 2015 Drug User Survey http://adai.uw.edu/pubs/

[44] HCA RHNI Starter Kit

[45] http://www.piercecountywa.org/4784/Mental-Health-Committee

[46] http://www.king5.com/article/news/local/tacoma/construction-underway-for-new-psychiatric-hospital-in-tacoma/480624937

ACH Theory of Action and Alignment Strategy

Vision

At Pierce County ACH, we start with one simple question: how do we make our community healthier? Our calling is to make sure the answer to that question can be tangibly connected to health reform. When it is, good things will happen.

PCACH convenes a diverse range of partners to catalyze a community transformation effort predicated on the principles of collective impact. We seek more than just alignment with the Healthier Washington priorities – our goal is to imbue those priorities deeply into Pierce County's social fabric. We want better prevention that keeps our residents healthy; we want higher quality care to be available when they need it. We want improved health to be a foundational value for our community, and we want to make sure that outcome is shared equitably by all. Our work is organized around the core principle that healthy, vibrant people and communities are better able to achieve their full potential, and that better health for all is the cornerstone of community vitality.

Overarching Approach to Transformation: We know this is a big goal, and to accomplish it we need more than a vision – we need a plan. PCACH has embraced the IHI Framework for Leadership for Improvement, which calls out three essential ingredients in the recipe of transformation: ***Will** to improve*, ***Ideas** about alternatives to the status quo, and **Execution** to make it real.* [47, 48] We organize our work around these essential elements of change in order to disrupt old ideas while making new ones into attractive alternatives. This kind of healthy, push-pull tension between old and new is how the energy needed to drive real change is generated and harnessed.

Figure 9. IHI Framework for Leadership for Improvement

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The Building Blocks of Change: Three important assets lie at the foundation of our transformation strategy: a set of strong community and provider/payer partnerships with an embedded shared learning

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47 Execution of Strategic Improvement Initiatives to Produce System-Level Results (Nolan TW. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007).

48 *IHI Framework for Leadership for Improvement*, Institute for Healthcare Improvement.

infrastructure, authentic engagement with our community to leverage local wisdom, and a rigorous emphasis on data as a driver of smart, community-based transformation. Regional data on disparities and poor outcomes drive our ***will to improve*** and help point us toward empirically supported solutions such as whole-person care, addressing the social determinants of health, and rewarding quality and value. Authentic community engagement helps us respond to that data and generate ***ideas*** that will work in the unique social ecology of Pierce County and addresses the needs of the whole population. We then ***execute*** transformation via our network of partnerships through environmental, policy and systems change that collectively and comprehensively address up-, mid-, and down-stream issues across our region, such as workforce issues, implementation of population health management strategies, and supports for a move toward value-based care. Our reliance on data and our strong shared learning system then positions us to monitor and evaluate our work, provide timely implementation feedback, drive process improvement, capture empirical evidence of community impact, and build a case for long-term sustainability.

Equity at The Center: PCACH will move past the Triple Aim[49] and embrace the Quadruple Aim,[50] which adds a strong provider lens to the goals of better health, better care and lower cost, because we believe strong provider partnerships are an essential element of any successful transformation plan. We place equity firmly at the center of these four goals – we seek transformation that not only improves our overall outcomes, but also improves equity in outcomes across each domain for members of our community. We see improving equity as distinct from simply reducing disparities; the latter is a tangible manifestation of the former, but our goal as an ACH is to explicitly address the systematic *causes* of disparities across the four dimensions of the Quadruple Aim.

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[49] Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012.

[50] Adapted from Rishi Monchanda, Health Begins & Institute for Healthcare Improvement, 2016.

Figure 10. Achieving the Quadruple Aim

Source: Adapted from Rishi Manchanda, HealthBegins & Institute for Healthcare Improvement. Updated: 11/09/2017
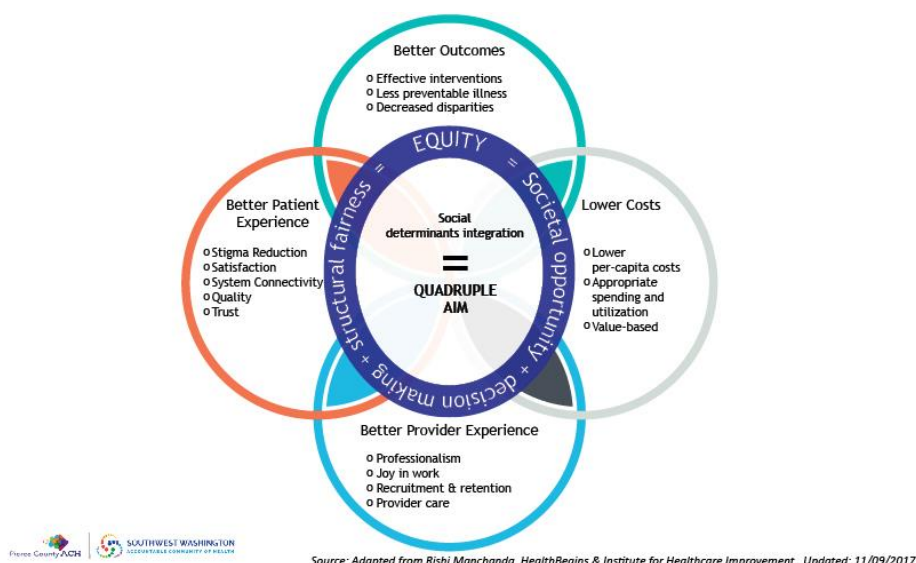
Strategies

Overall Strategy: Our strategy is to identify the settings where people who currently experience the greatest inequities are engaged in services, then transform the experience they have within and across those settings by building upon the effective elements that are already in place and spreading them across the region. These settings include but are not limited to healthcare delivery; we will also work across community-based social services, the public safety sector, emergency services, and other sectors. This approach necessitates a very strong provider focus – the experiences people have in key settings will only change if those who provide services in those settings are an integral part of the change we are trying to create.

We live in a profoundly interconnected world. The way vulnerable persons move through systems reflects that interconnectedness, but the systems themselves rarely do. In addition to improving care *within* key settings, we will also improve connections *between* those settings. We will work to create a coherent experience for our priority populations across disparate settings such as primary care and behavioral health clinics, hospital EDs, emergency response systems, jails, and social services agencies; one where the service providers in each of those settings have the tools and supports they need to work together in service to a shared vision and common goal. We see our job as holding and presenting that vision, engaging the community around the vision, providing supportive tools and resources, and using our data infrastructure to support the transformative work our partners are doing, capture evidence of impact across the spectrum of community partners, and apply that evidence to build a sustainability plan that ensures our work continues over the long term.

Figure 11. Transformation of Care and Service Delivery Settings Model

Figure 11. Transformation of Care and Service Delivery Settings Model
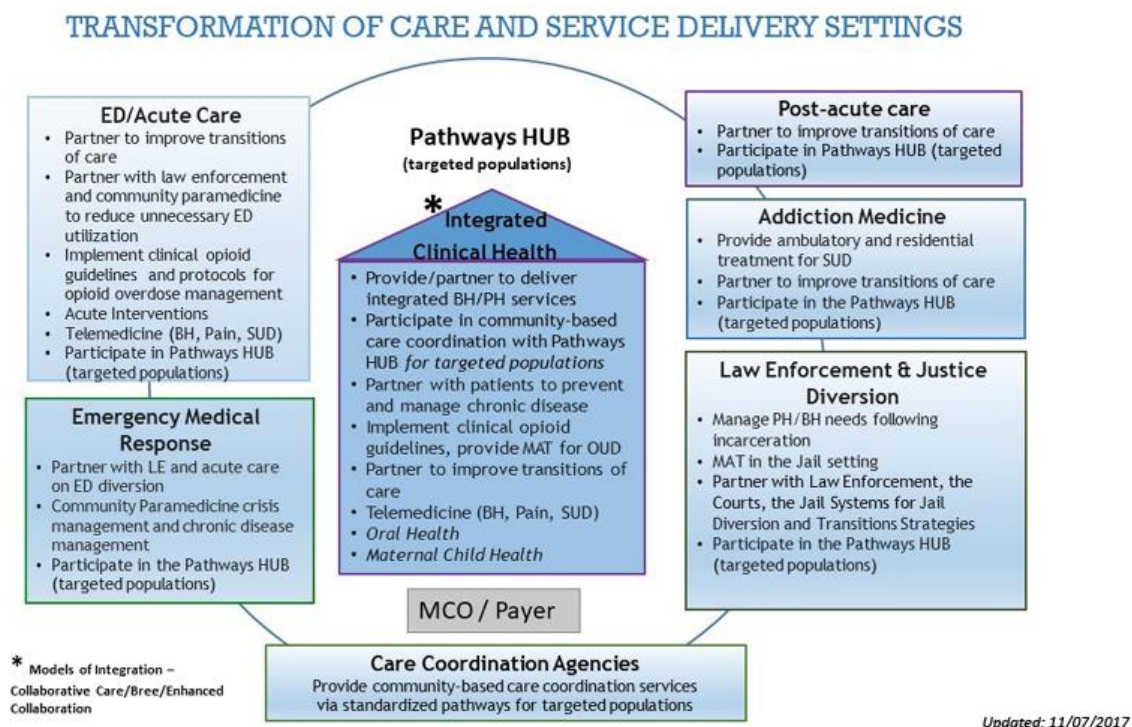
Strategic Aims: Our overall strategy will be realized across three specific aims that encapsulate what we are trying to achieve.

1) **Achieve Whole-person Health using a Quadruple Aim Framework.** Under this aim, we will work to transform the care system in our community to better address the needs of the whole person, including physical, behavioral, and oral health needs as well as their social determinants of health challenges. As a result of this work, we will increase timely access to care across the various domains of whole-person care, optimize how populations utilize services, improve the experience of care for patients and providers, improve management of chronic conditions, and ultimately reduce the per capita and total costs of care across our community.

2) **Enhance experience, quality, and value for health improvement.** Under this aim, we will work to move our community's care systems toward a high-quality, value-based model organized around the fundamental goal of creating health rather than delivering services. As a result of this work, we will move systems toward value-based payment, increase the use of alternative workforces as a part of a comprehensive system of care, improve workforce capacity, increase provider satisfaction, and adopt HIT/HIE systems that connect in ways that support population health management.

3) **Value shared learning, continuous improvement, and community resiliency.** Under this aim, we will work to improve our community's capacity for collective impact – our ability to identify and solve problems together. As a result of this work, we will build and maintain a shared learning infrastructure with data at its core that allows us to identify data-driven opportunities

for collective action, engage with our communities to identify and generate workable solutions, create rules of engagement and resources for change management that enable effective implementation of those solutions, monitor performance and provide feedback, capture evidence of savings or other community impacts, and reinvest those savings back into the community via a *community resiliency fund* that supports health-generating activities and programs over the long term.

A Catalyst for Larger Change: We have designed our strategy from the ground up to have a catalyzing effect on our community. While activities within our three aims will initially focus on priority populations, our intent is to build systems that scale across and benefit other populations, including non-Medicaid lives. As the PCACH, we recognize the importance of starting with a clear focus on priority populations in order to create evidence of impact and support the goals of Washington's Medicaid MTP Project. We do not see the MTP Project as the end of our work, however. Our ultimate charge as an ACH is to improve the health of everyone in our region.

Selected Projects

How Our Project Areas and Our Strategy Fit Together: We will implement our overall strategy across four key project areas—two focused on *Care Delivery Redesign* and two focused on *Prevention and Health Promotion.* We see each of the four as contributing a key element to our overall transformation strategy:

1) **Bi-Directional Integration:** In this project area, we will engage and support providers in moving toward a comprehensive approach to health and creating improved experiences within physical and behavioral health settings, building on our status as a mid-adopter for integration. This is especially critical for our priority populations, who often struggle with complex and multi-dimensional health challenges and are poorly served by a fragmented system.

2) **Community-based Care Coordination:** This project area allows us to engage and support providers with tools that improve the connectedness of experiences across clinical and other community systems. This is foundational to creating a coherent framework for whole-person health that includes addressing the non-clinical levers that shape population health outcomes. Our Pathways Model also opens the way for payment reform to help drive transformation as MCOs can invest resources toward addressing the social determinants of health.

3) **Chronic Disease Prevention and Control:** This project area allows us to move our systems away from responding to sickness and toward creating better health as an organizing principle, a move that is an essential element of value-based payment and population health management. It also helps create supports for individuals to manage their health challenges and achieve their health goals, which will be critical to reducing the total long-term burden of complex health on the systems and partners in our community.

4) **Addressing the Opioid Use Crisis:** This project area allows us to address a critical public health crisis that can only be effectively addressed by a strategy that focuses on the needs of the whole person, including the social determinants of health, and via the range of key care settings we have identified. It will act as a key test case for the efficacy of our collective impact model.

PCACH selected these four areas as foundational initiatives based upon regional health needs and stakeholder input. However, our board and our shared learning stakeholder structure voted that we also

address the project areas that were not selected (oral health, reproductive and maternal child health, transitions of care, and diversions) by subsuming or linking them into our planned work for the areas we did select. Thus, while PCACH will focus on the four key projects identified above, our work on the ground is designed to address the full range of potential project areas under MTP.

Figure 12. MTP Projects Strategic Approach
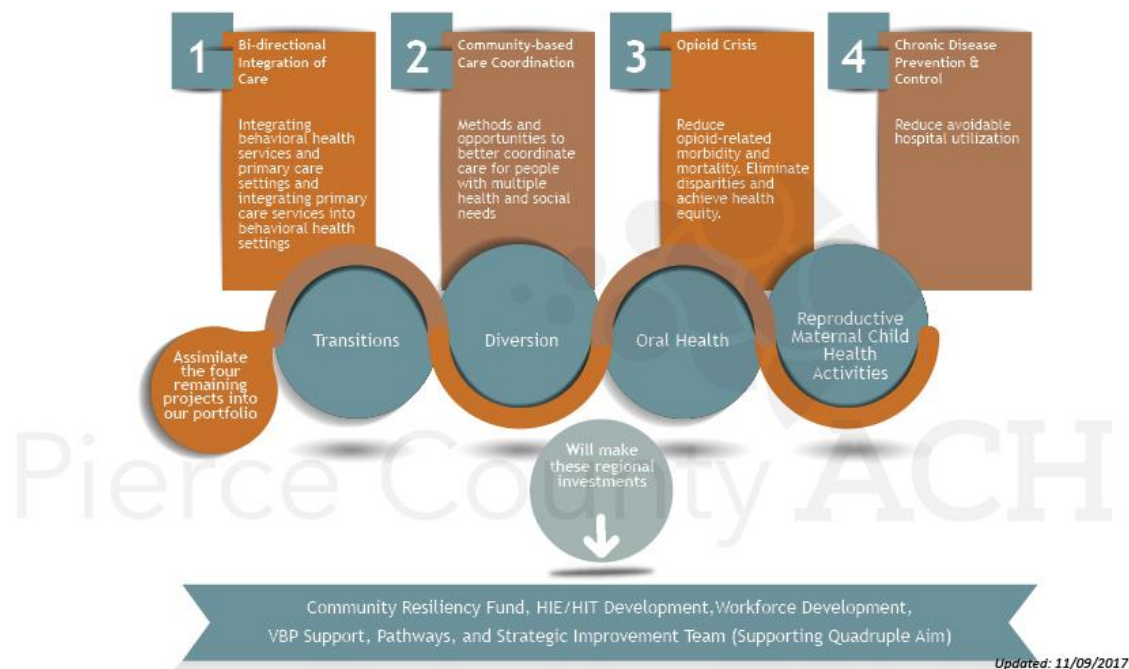
What PCACH Will Do to Drive Our Strategy Forward: Because our strategy is centered on improving experiences within and between settings of care, our partners in the community will play a key role in implementing the changes our community needs to make to achieve its goals. PCACH may not directly manage those care settings, but we envision a distinct role for the ACH to drive and support the strategy across five key areas of work:

1) **Build and Maintain a Strong Collective Impact Coalition:** PCACH will act as the key backbone for our community's coalition of cross-sector partners, bringing together healthcare delivery partners, local and state government partners, Medicaid beneficiaries, MCOs, and other stakeholders to re-examine how our care settings can transform to achieve our goals. Our governing structure will serve as the hub by which collective decisions can be made, implemented and supported in service to a common vision. It will also act as a forum for identifying and pursuing the systems change and policy work that will complement and enhance the impact of our projects.

2) **Maintain Authentic Community Engagement:** PCACH will serve as the hub for continued, authentic community engagement. We will ensure that the voices of our priority populations, cross-sector partners, and providers are heard across the range of our portfolio, that what we do is informed by local wisdom, and that we continue to do things *with* rather than *to* or *for* our providers and community members.

3) **Ensure that Data is at the Heart of the Community's Work:** PCACH will hold and deploy data in ways that fundamentally inform and drive our collective strategy. We will use our data systems to refine and focus efforts on the populations and settings where we can have the greatest impact, support implementation and quality improvement through our shared learning system, monitor and measure the impact of our work over time, and generate empirical evidence of community impact across sectors that can help sustain and spread our work.

4) **Drive Transformation Activities Across Our Project Areas:** PCACH will also act directly to support activities essential to our four project areas. While our partner organizations focus on implementing specific changes within our identified care settings, the PCACH will focus on services that *enable and support* those efforts by creating infrastructure essential to their success, including but not limited to:

   a. Elevating and integrating the social determinants of health as a critical component of how all systems engage with our priority populations;

   b. Ensuring that equity is a core value and shared goal for all partners, and providing data in support of that goal;

   c. Identifying and making strategic investments in prevention and recovery;

   d. Building supports and tools that incentivize and enable stronger links between clinical and community providers and extend care beyond healthcare walls;

   e. Incentivizing and supporting healthcare systems and providers to progress along the continuum of integrated care;

   f. Incentivizing and supporting partnerships and tools that aid in transitioning high-risk populations into better care management;

   g. Supporting the community in building a community-based care coordination system that pays for performance; and

   h. Supporting the development of programs and workforce to connect priority populations to health care systems and other community supports.

5) **Demonstrate Impact to Drive Sustainability and Spread:** Finally, our efforts toward health transformation will be futile if we cannot sustain and spread them at the end of the MTP Project. PCACH will create and maintain a *community resiliency fund* that acts as a holding place for braided funding to support prevention and health-focused transformation efforts in our region. Additionally, PCACH will support local evaluation efforts designed to supplement the state's overall wavier evaluation; our local efforts will be designed to demonstrate the *total community impact* of our efforts on outcomes of interest to key partners in our region, attracting cross-sector investment in the wellness fund and ensuring our ability to sustain and spread transformation in Pierce County beyond the life of MTP.

Process for Selecting a Portfolio

To select projects, PCACH established a cross-sector RHIP (*Regional Health Improvement Plan*) Council and a PIP (*Provider Integration Panel*) as part of its governing structure and charged them with making recommendations about project selection to the Board of Trustees. The councils developed a two-level

criteria model upon which they based those recommendations, including a set of *threshold* criteria that projects must fulfill for consideration, and a set of *next-level* criteria used to narrow the focus to projects with the highest impact potential.

Criteria

Threshold Criteria: This set of minimum criteria defined which potential projects could be considered for potential adoption. It includes:

- Alignment: Fidelity to regional health priorities and the ACH mission and values.

- Efficiency: Ability to address documented need without duplication of efforts.

- Impact: Potential to impact Medicaid cost, quality, or health outcomes within 2-3 years.

- Scalability: The potential for spread and scale across the region and impact broader populations as part of our ACH's population focus.

- Readiness: The region's readiness to implement the project.

Next Level Criteria: This set of criteria were used to differentiate between potential projects at a finer level and select those with maximum impact potential. It includes:

- Health Equity: Whether the project reduces disparities or advances health equity.

- Data/Measurement: Whether the project is data driven in terms of defining populations, sharing learnings, and measuring outcomes.

- Legal: Whether the enacting partner has legal authority, and whether implementing the project might impose potential legal vulnerabilities.

- Breadth of Support: Whether the project is controversial; whether there is clear readiness in the community to act now.

- Practicality: Whether the project builds on existing efforts and presents a clear role for PCACH. Whether it can be self-sustaining or will require ongoing investment of resources.

- Social Value and Whole-population Focus: Whether the project is multi-sector and has a clear connection to improved quality of life and other shared community goals across the entire regional population.

- Earnings Potential: Whether the project has high earnings potential based on the HCA incentive payment weighting formula.

Whole-Population Vision for Health Systems Transformation

How We Narrowed It Down: Our shared-learning structure of councils, panels, Data and Learning Team, and workgroups conducted environmental scans to assess the current state of resources and gaps in the region across all eight potential project areas. These workgroups evaluated the projects by comparing data from our RHNI and the environmental scans against the criteria defined above. To ensure deep community engagement and a "whole-population" focus. We also conducted one-on-one interviews with a wide range of community and provider organizations. Feedback from these twin processes was then combined to create project selection recommendations for the RHIP and PIP

Councils to advance to the board.

Results: Both the PIP and RHIP originally recommended a six-project portfolio. The workgroups and RHIP also recommended that aspects of the other projects (oral health and reproductive and maternal child health) be incorporated into the PCACH project plan. However, the recent announcement of reduced MTP funds prompted the PIP to recommend a more focused, targeted Project Portfolio. In the end, the board approved a focus on four project areas: Bi-directional Integration, Community-based Care Coordination, Chronic Disease Management, and Addressing the Opioid Crisis. However, because of the policy and systems change lens that underlies the work we do within our targeted care settings, the board recommended PCACH still work to meaningfully address the four project areas not selected. Thus, our portfolio will focus on four key projects, but our strategies will be designed to drive improvement across all eight potential project areas.

Shared Interventions, Resources and Infrastructure

We have adopted a systems approach for transforming care and service delivery settings in order to improve experiences within and between those settings while incentivizing provider collaboration and partnerships. To support this work, PCACH will provide a range of shared services and infrastructure, funded through the designated DSRIP incentive funds.

Common Understanding—The Transformation Rules of Engagement: Once our projects were selected, PCACH and its stakeholders collaborated to create a set of *Transformation Rules of Engagement* that define what partners must commit to in the context of participating in our project work for each care setting within which transformation is occurring. These rules act as a common framework for all partners and settings about what participation in any of our given project looks like and are spelled out in detail within each of our respective project descriptions (See attachments: *Transformation Rules of Engagement* and *Strategic Aims and Drivers*). Examples of activities and standards that have been adopted under the rules of engagement include, but are not limited to:

1) A common set of trainings around domains such as awareness and sensitivity, cultural competency, equity, trauma-informed practice, and other key focus areas;

2) Consistent use of validated instruments to screen for behavioral health conditions and/or substance use disorders;

3) Standards for screening for tobacco use and offering cessation counseling to smokers;

4) Standards for trauma-informed care and practice;

5) Commitment to and standards for inquiring about access and care for oral health, along with systems for referral;

6) Adoption of a "one key question" standard for screening individuals about their intentions around parenting;

7) A set of standards around implementing telehealth and mobile services; and

8) A standard of training for de-escalation and recovery-oriented care.

By mapping activities to appropriate delivery settings using the Transformation Rules of Engagement, PCACH creates a common set of approaches and standards that define the work that will be done under its umbrella. With this alignment comes the ability to develop and offer a coherent set of shared

interventions, resources, and infrastructure in support of that regional work.

To support our common set of approaches, PCACH staff, the PIP, partner work sessions to-date with large systems such as MultiCare, CHI Franciscan and Sea Mar and Community Health Care, Opioid Workgroup, Care Coordination Advisory Workgroup, Data and Learning Team and RHIP have developed and adopted the Transformation of Care and Service Delivery Settings (Attachment 113), Transformation Rules of Engagement (Attachment 1), Strategic Aims and Drivers (Attachment 2) and Science of Improvement methodology (Attachment 110) that delivers a solid foundation for implementation preparation. Several clinicians serving on the PIP have co-authored white papers providing guidance on bi-directional integration of physical and behavioral health (comparing and contrasting Collaborative Care Model and Bree Collaborative overlays, providing a guide for a blended model in Pierce County), the Wagner's Chronic Care Model and Primary Care Medical Home. The White Papers and tools listed above serve as our MTP roadmap and have been placed into PCACH's draft Transformation Action Plan (the Action Plan). The Action Plan is guiding our implementation preparation for the regions partnering providers and creates a strong foundation for common understanding. PCACH's Board has adopted the recommendations above.

Shared Infrastructure: In support of the common standards for transformation laid out in the rules of engagement, PCACH will provide the following:

1) PCACH Staff, who will oversee and coordinate community transformation support efforts.

2) A *Population Health Management System* via the *Pathways Community HUB*, along with coordination of complementary HIT/HIE strategies across partners.

3) *A Data and Analytics Platform* in support of self-monitoring and evaluation, via a partnership with the Center for Outcomes Research and Education (CORE).

4) A *Strategic Improvement Team (SI Team)* staffed by clinical and non-clinical advisors with experience in a wide range of transformation domains and activities and charged with delivering technical assistance to partners.

5) A *Community Resiliency Fund* that will be housed at the PCACH and used to spearhead regional, community-led initiatives aimed at strengthening resilience through social determinant investments and key policies and system changes for population health, with activities selected using the same guiding principles PCACH applied to define its initial program selection.

Figure 13. Community Resiliency Fund

Community Resiliency Fund
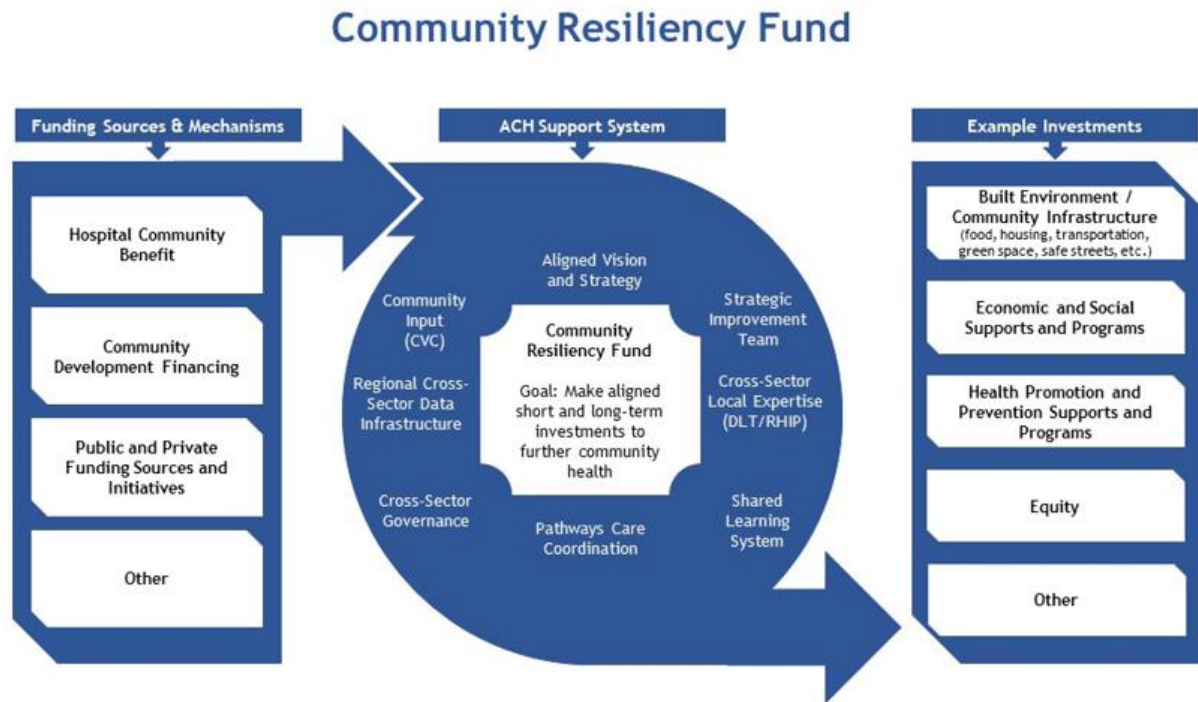
Shared Services: Coordinated Technical Assistance in a variety of domains via the *Strategic Improvement Team* or other contracted resources, such as the *Practice Transformation Support Hub* managed by the state Department of Health Services. Available services will include:

1) Facilitation, coaching, training, and other consultation services;

2) Project management and change management support, especially as it relates to implanting the Transformation Rules of Engagement;

3) Workforce development strategies, including skills building, improving retention, and reducing burnout;

4) Assistance with contracting, billing, and development of value-based purchasing;

5) Communications support for internal and external audiences;

6) Development of policies and procedures that support transformation goals and activities;

7) Self-monitoring and reporting, including the dissemination of data to support rapid-cycle feedback and process improvement;

8) Best practices in accountability and the science of improvement, including how to use data to drive meaningful organizational change;

9) Tools and capabilities designed to support pay for reporting; and

10) Other tools and technical assistance as needed.

How Shared Services will be Deployed across Projects: The PCACH Quality and Continuous

Improvement (QCI) Workgroup is accountable to support partners in their transformation efforts across all project areas. The QCI Workgroup will connect regularly with implementation partners to identify potential gaps or receive and curate requests for technical assistance; their work will be combined with data from our *data and analytics* infrastructure to develop a comprehensive set of recommendations. The QCI Workgroup will then recommend a set of responsive quality improvement plans to the Provider Integration Panel for adoption and implementation. When needs are defined, and a plan is approved, coaches from the SI Team will be deployed to provide the relevant assistance to community partners on Plan, Do, Study, Act (PDSA) quality improvement cycles.[51]

Region-wide Health Outcomes

PCACH has developed a blended improvement framework based on the model of IHI Science of Improvement Model[52] and The Improvement Continuum (AHA),[53] and we have been actively developing and deploying this strategy in our partnering provider organizations. Under this framework, we develop a *testing and feedback loop* that implements activities across the program areas and is supported via our measurement and data infrastructure. Each of our program activities is built on a logic model that defines long-term population outcome goals and a set of precursor indicators that represent progress toward those goals, and our data infrastructure will be built from the ground up to connect the specific activities within each project area to that list of interim and population-level outcome indicators.

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[51] Associates in Process Improvement funded by Institute for Healthcare Improvement

[52] Adapted from "Improvement Framework", Institute for Healthcare Improvement

[53] "Leading Improvement Across the Continuum: Skills, Tools and Teams for Success" 2013. Chicago: Health Research & Educational Trust. Copyright 2013 by the American Hospital Association

Figure 14. Improvement Framework
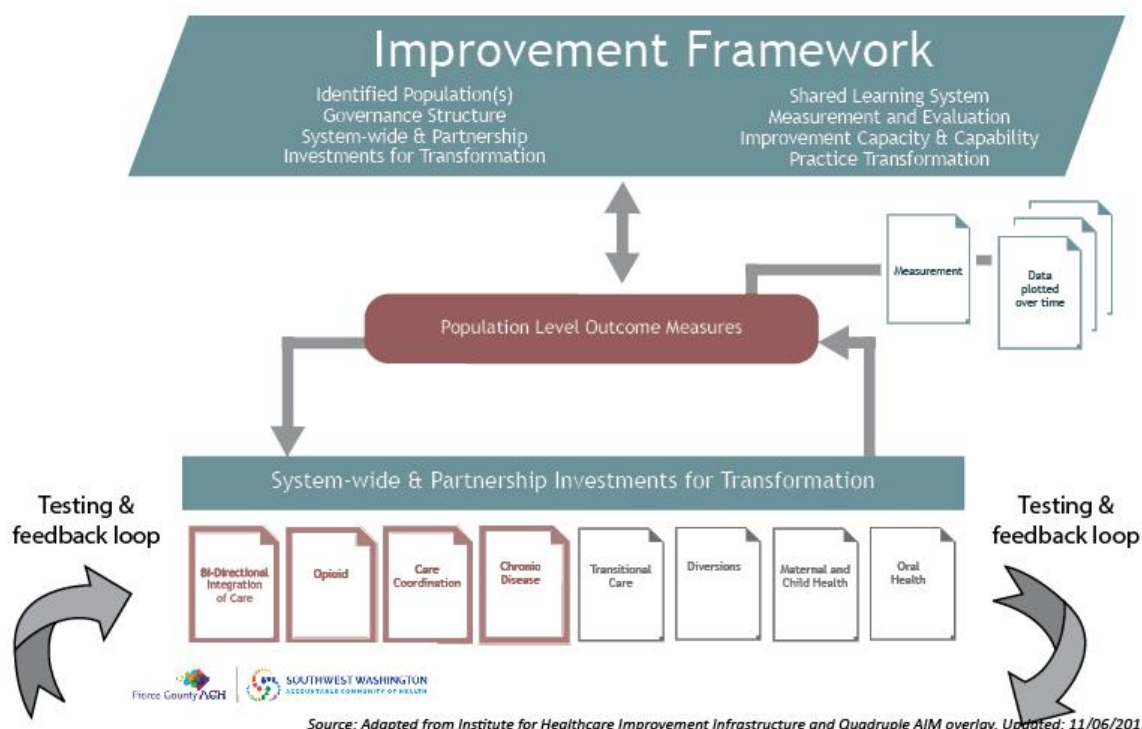
Figure 15. The Improvement Continuum

Spread of Impact: We initially focus on our priority populations to build a connected system of care, but the systems we build should not and will not be limited to those populations. Our work within these

priority populations is entirely predicated on the idea that we will extend and scale the systems and approaches we build to other populations across the region.

Lever for Moving Health Outcomes: PCACH's strategy for improving health outcomes in our region is predicated on the idea that we live in an interconnected world, and that the drivers of poor health are consequently complex and interrelated. No single system can improve population health on its own because population health exists at the intersection of health care, social services, public safety, and other related systems, especially for populations with complex health and socio-economic challenges. Creating a better-integrated and more comprehensive approach to community care will allow providers to address the disparate drivers of poor health simultaneously as part of a coordinated strategy; the result should be enhanced prevention and improved experiences of care within and across all systems, ultimately leading to improved health outcomes. Key levers for regional health include:

1) Integration: Aligning and integrating care and service systems across sectors.

2) Transitional care: Improving the way people move between systems and sectors.

3) Diversions: Diverting populations into more appropriate care settings.

4) Care Coordination for Populations: Connecting persons with complex health challenges to the full range of resources needed to improve their status.

5) Chronic Disease Management for Populations: Supporting individuals with complex health in managing their conditions and preventing acute exacerbations.

6) Social Determinants of Health: Address the upstream drivers of poor health, such as housing, transportation, food security, financial health, and so on.

Region-wide Quality, Efficiency and Effectiveness

Lever for Improving Quality, Efficiency, and Effectiveness of Care: Our strategy for improving quality, efficiency, and effectiveness is based on the idea that a shared learning structure can identify and spread best practices across the disparate partners that make up our region's care and services infrastructure. Key levers for improving these outcomes include:

1) Workforce Development: Activities that engage and support caregivers and help them develop the new skills they will need in our emerging model of community practice.

2) Value-Based payment: Developing ways to incentive organizational behavior that enhance quality and promotes efficiency.

3) Population Health Management: Mapping and connecting data in ways that allow for a cohesive approach to managing care and outcomes across the community continuum.

4) Fully Integrated Data Support: Developing analytic tools and models that help target populations and settings for optimal impact, putting data in places where it can drive shared learning and process improvement.

5) Evaluation and Learning: Systematically evaluating regional transformation to capture empirical evidence of impact, then using that data to sustain the collective work and spread the model to other populations and priority areas.

An example of a profound lever for efficiency and effectiveness, facilitated by PCACH, is alignment of

our local community health centers with our large health systems to jointly care for Medicaid patients. This aligned care and service delivery model would lead to more comprehensive care, better coordination and more efficient use of resources. This alignment will allow a fuller use of the enhanced Federally Qualified Healthcare funding to care for Medicaid patients. This partnership is a basic augmentation to the local safety net and increases access leading to enhanced capacity. PCACH is looking to engage more partnering providers in this type of activity to further efficiency and effectiveness in our region.

Health Equity

Lever for Improving Equity: Health equity has been a foundational element in all matters of project design for PCACH. To ensure that individuals facing the greatest health disparities inform the community needs assessment and improvement opportunities, PCACH has focused on building diverse representation at all levels within its governing structure, and we intend to actively pursue improved equity as a goal for our region. Key levers for improving regional equity include:

1) Use of Data to Track Disparities: Our data infrastructure will be designed to explicitly track progress against all measures in terms of disparities in outcomes, and to make that data transparent and available to all community partners.

2) Use of CHWs and other Community-based Workers: Our adoption of the Pathways Model for Community Care Coordination includes a robust set of supports for leveraging and expanding the use of CHWs as part of our systems of care.

3) Embedding Equity in Project and Vendor Selection: PCACH has required potential projects partners, such as the Care Coordination Agencies (CCAs) embedded within the Pathways Model, to demonstrate a commitment to health equity and deep experience in supporting the diverse cultural, linguistic and geographical needs of Pierce County members.

4) Community Trainings: We will ensure community trainings are available in multiple languages and across diverse cultural and geographical community sites. Our board and other key staff will also receive intensive training on diversity, equity and inclusion.

5) Cultural humility and Trauma-Informed Care: These will be incorporated as essential components of the Strategic Improvement Team's work as it embeds itself within our community partners to support transformation efforts.

6) Equity Lens on Policies and Systems: An equity lens will be critically applied to all policies, procedures, and systems (i.e., hiring processes established that enhance diversity and inclusion in the workplace).

Role as an Integral, Sustainable part of Regional Health System

Becoming an Integral Part of the Regional Health System: PCACH views itself as the essential backbone of the transformed regional health system, tasked with housing the shared governance, resources, and data that support cross-sector transformation. As a neutral party who can add value in ways specific partners within sectors cannot, PCACH is positioned to fill the following key roles relative to long-term regional health transformation:

1) Convene care and service delivery partners, payers, governmental agencies, Tribal Nations, and patients to continue transforming the regional health system.

2) Identify and leverage other dollars for braided funding opportunities.

3) Support care and service delivery partnerships with financing, workforce development, regional population health management systems, and assistance in transitioning to value-based contracting/payments.

4) Partner with consumers and community members to engender the trust of community and amplify voice of those most impacted.

5) Implement and support cross-cutting strategies to address social determinants of health;

6) Facilitate learning and shared decision making to identify policy and systems challenges.

7) Enhance experience, quality, and value for health improvement.

8) Hold and distribute data from multiple partners that can be used to help support implementation, quality improvement, and impact evaluation activities;

9) Develop and manage the *Community Resiliency Fund* with braided funding to support additional transformation work in the region.

Sustainability Strategy: PCACH will develop a multi-pronged sustainability strategy built around the concept of *total community impact:* demonstrating the primary impacts of our work on the collective goals of the ACH, and the secondary impacts of our work that "ripple" through connected systems to their collective benefit. For example, work to improve whole-person health in our priority populations might also reduce jail recidivism in those populations, or make their children more likely to attend school regularly. These secondary impacts exist because the populations that struggle in one sector often struggle in others, because improved outcomes in one sector are often a necessary precondition for improved outcomes in another, and because the outcomes that matter to distinct sectors often share a common set of root causes. When we address a root cause toward our common ACH goal of whole-person health, we are also addressing the causes of other key challenges our partners grapple with every day.

Capturing that value is the key to long-term sustainability. Under this approach, our local evaluation plan *is* our long-term sustainability plan: it will be built from the ground up to measure the *total community impact* of our work in a way that positions us to attract braided funding and resources across sectors in order to help sustain and spread our work.

In addition to the total community impact framework, additional sustainability strategies will include the following:

1) Shared Savings: We will use our data and evaluation capabilities to capture shared savings, with a portion of those savings supporting the ACH and a portion re-invested in the community via the *Community Resiliency Fund* or other mechanisms.

2) Strategic Improvement Services and Service Line Contracting: The services we provide in support of transformation can eventually move toward fee-based or PMPM support models. Data from our impact evaluation can be used to help us develop appropriate pricing models for these services.

3) Philanthropy: We will actively engage with local, regional, and national foundations to support our innovative population health model.

4) Grants: As we develop and implement innovative approaches to improving population health in our region through the Resilience Fund or other resources, we can attract interest from local or national funders interested in using our work as an opportunity to test those innovations and potentially spread them to other states.

5) Partnerships outside the Medicaid market: As our work expands beyond the Medicaid market, we will leverage emergent opportunities to engage with the business sector or other partners who may be interested in applying our population health work within the context of workplace wellness or other initiatives.

Phase II Certification Feedback

*(*Please see above, feedback addressed in narrative.)

Governance

PCACH is a neutral, convening, community-based organization with a stakeholder-heavy structure by design, with a clear separation between governance and operational management, and the need for local communities with the vision, leadership and commitment to extend health service integration This structure represents solution shared-learning structure in order to sustain successful relationships and accountability among diverse partners, well beyond MTP. Governance is comprised of community partners who lead or have deep knowledge and experience of the care and service delivery settings, as well as community members, elected officials, providers and provider systems, and community leaders. The structure is composed of the following bodies: Board of Trustees and the committees of the Board; Executive Committee; Nominating Committee; Finance Committee; Waivers & Investments Committee; CVC; RHIP; PIP; DLT and new subject matter experts in small workgroups for Quality and Continuous Improvement; HIT/HIE; Value-based Payment, Workforce Development; Opioid and Care Coordination Advisory.

Figure 16. PCACH Shared Learning and Interconnected Governance Structure
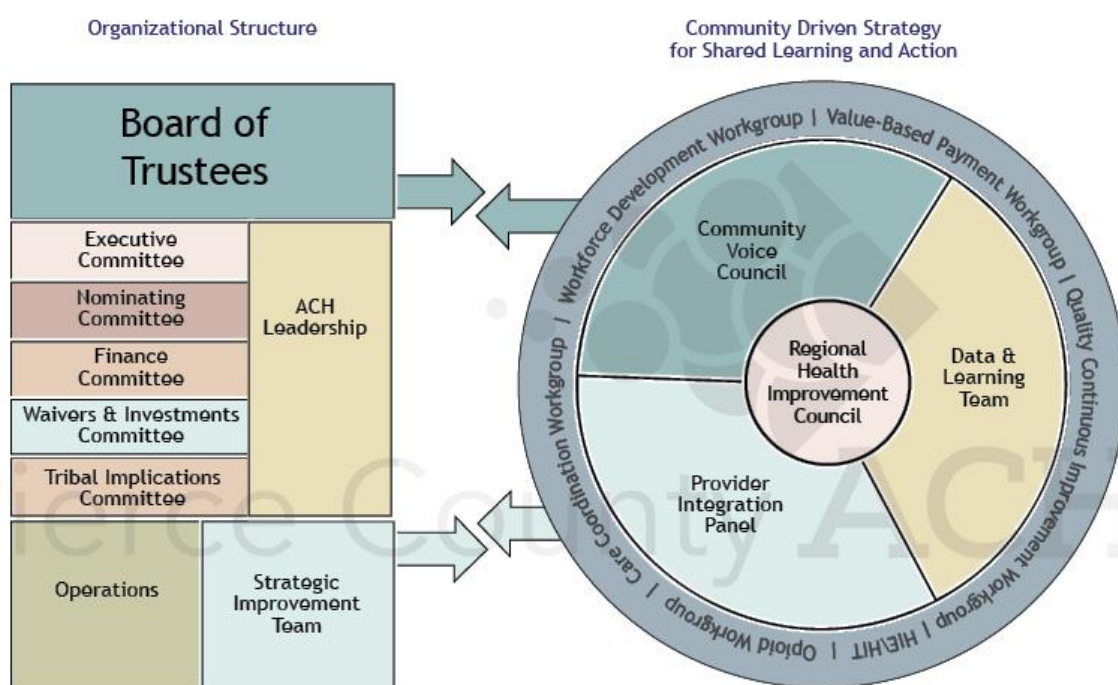
Updated: 11/07/2017

Board of Trustees: The Board is responsible for oversight and assurance that the work of PCACH is financially sound, legal, and in service to the collective vision of the community. The final decision-making body, or single point of accountability, is the Board of Trustees (the Board), who serve in a traditional, non-profit board capacity. The term "trustee" was selected before the non-profit was established. It was important to the community to use a term that implies stewardship of the sector or community perspective rather than the individual board member's perspective. The Board includes members from multiple sectors and organizations that serve Pierce County and influence health outcomes. This includes two CEOs of MCOs. Committees of the Board include the Executive Committee, Tribal Implications Committee, Finance Committee, Nominating Committee, and the Waiver & Finance

Committee. Board Roster and Executive Committee Biographies are attached. (See Attachments 4 and 5)

Executive Committee: The Executive Committee is made up of officers of the Board; President (Chair), Vice-President (Vice-Chair), Secretary, and Treasurer, and the Chief Executive Officer (CEO). The committee has the authority to conduct business on behalf of PCACH between regular Board meetings as expressly authorized by the bylaws and Board. The Executive Committee is comprised of individuals in the following sectors: provider clinic, community-based organization (housing, social services), health system and behavioral health (also a representative of Pierce County Human Services Coalition). The Executive Committee currently serves as the Tribal Implications Committee* until such time that Tribal Government representation is secured on the Board.

*Tribal Implications Committee: Currently, the Tribal Implications Committee sits with the Executive Committee and they monitor the potential consequences of MTP work on American Indian/Alaskan Native (AI/AN) populations and Tribal engagement strategies of PCACH. This Committee will stand as a separate board committee once PCACH has Tribal Government representation on the Board.

Finance Committee: The Finance Committee is responsible for the financial health of the organization. This Committee provides fiscal and compliance oversight for PCACH, including audit and operating budget oversight. They directly report to the Board for final approval of budget and expenditures. PCACH CFO (with deep expertise in health systems and behavioral health financial and revenue-cycle management, as well as CPA experience) is the leadership who staffs this Board Committee and has oversight of the finance department, which currently consists of a tenured senior financial analyst and an administrative accountant.

Waiver and Investments Committee: This Committee is comprised primarily of independent members and Board representatives. It also includes executives of the three MCOs currently not seated on the Board. They provide guidance and direction for all MTP-related funds and investment strategies, including management of the Community Resiliency Fund. The Committee approves Waiver and Investments policies and guidelines for the PCACH, submits recommendations to the Executive Committee and the Board regarding allocation of all funds, and provide ongoing oversight of outside funding plans.

Nominating Committee: The Nominating Committee is vital to the governance of PCACH. It ensures the shared learning structure and the Board are made up of diverse representatives from a multitude of sectors and geographic areas of Pierce County so that health inequities are raised and incorporated into the strategy work of PCACH. The Committee is made up of five individuals: The Board Chair and four elected individuals from the Board and the community. The Committee regularly assesses all Council and Board committee strengths and weaknesses according to Board-established elements for the ideal member profile and identify necessary skill sets and experience, and then approve nominees accordingly.

Provider Integration Panel (PIP): Comprised of a group of leaders and clinicians who provide behavioral, physical and general healthcare in Pierce County and understand the key components and barriers of healthcare transformation. They use regional data and expertise to recommend specific interventions and shared learning to understand policy and system barriers or innovations to address access to care, clinical integration, chronic disease management, opioid use and its impact, care transitions, diversion to the best care setting, oral health, and reproductive and maternal and child health. Chair: Joe Huang, MD Regional Primary Care Medical Director, MultiCare; Vice Chair: Dimitry Davydow, MD, MPH Medical Director of Behavioral Health, CHI Franciscan

Regional Health Improvement Plan Council (RHIP): Comprised of members from the healthcare delivery system, including physical, behavioral, and oral health, MCOs, early childhood, K-12, and post-secondary education, housing, criminal justice, public health, and community stakeholders. Made up of the community-at-large members to capture local expertise, work already happening in Pierce County, and a cohesive view of the regional picture. The RHIP receives input from the CVC, PIP, DLT and workgroups to then move forward recommendations to the PCACH Board. Draft RHIP Charter and Roster are attached. See Attachments 6 and 7. Chair: Steve Woolworth, Vice President of Treatment & Reentry Services, Pioneer Human Services; Vice Co-Chairs: Rosanne Martinez, Signature Service Director, Behavioral Health / Adoption / Secure Families, Children's Home Society of Washington; and Russ McCallion, Assistant Chief of EMS and Public Education, East Pierce Fire and Rescue.

Community Voice Council (CVC): The CVC has a direct line to the Board, separate from the RHIP, in the form of a voting seat at the Board table. CVC members are chosen for their experience with social conditions of health, the health and human services network in Pierce County, and firsthand understanding of the difficulties in navigating a fractured health care system. They contribute their expertise into the shared learning structure in the same way providers share their perspective and expertise, ensuring a more complete vision of whole person health and protecting our criteria of increasing health equity. For additional information on the community capacity of PCACH, review the Community and Stakeholder Engagement section of this document. Draft CVC Charter and Roster are attached. See Attachment 8 and 9. The CVC self-selected to not have chairs or vice chairs as they want a structure where all voices are heard equally.

Data and Learning Team (DLT) is comprised of data and analytic expertise from regional cross-sector partners. The DLT supports data driven decision making by reviewing and interpreting existing data and reports, identifying data gaps and data sharing needs, and making recommendations regarding project and target population selection to leadership and other governance groups. This group supports all areas of PCACH and the providers and partners participating in the MTP.

Per our interconnected governance shown in Figure 18, PCACH has a range of checks and balances to overall accountability, deep community engagement, and focus on addressing health equity. There are additional mechanisms required to be truly effective. These mechanisms are outlined below with our operational support team and workgroups.

Our workgroups noted below do not have decision-making authority, they provide critical expertise and operational expertise to the overall shared learning and action of the PCACH plan. These workgroups and teams provide recommendations that flow up to the councils, panel and ultimately to the Board for approval of action plans. The workgroups outlined below provide a unique function that allows the collective governance outlined above to make informed and sound decisions.

Workgroups Engaged and Active in 2017

Opioid Workgroup is comprised of multiple partners engaged in opioid-related work or who possess expertise throughout the county. These include hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs and the criminal justice system. Their function was to craft PCACH's approach to leverage existing efforts and expertise, fill gaps, avoid duplication, and target areas that require additional focus and resources. The Opioid Workgroup will convene on a as needed basis to ensure we are not duplicating existing efforts and/or to address any policy or system barriers to address the opioid crisis. The Opioid Workgroup works in conjunction with the Opioid Taskforce convened by Pierce County Government. To ensure alignment and cooperation, Councilmember Derek Young sits on both the Workgroup and the Taskforce.

Care Coordination Advisory Workgroup is comprised of a broad set of stakeholders and partners including hospital systems, behavioral health providers, community-based organizations, representatives from county government, MCOs, CHWs and the criminal justice system. This workgroup has supported the environmental scan and community mapping exercises to identify potential areas of overlap or duplication as part of the HUB planning process. This group will meet on a as needed basis. The Pathways Community HUB model requires interconnected governance and operational expertise. It is an integrated structure that allows for *accelerated* care and payment transformation, ambitious healthy equity agendas, and sustainable healthy communities.

Workgroups to be launched in January 2018

Value-based Payment Workgroup will be comprised of experts in revenue cycle, contracts and finance. They will track the statewide Medicaid Value-based Purchasing Action Team (MVP) and link the learnings back to Pierce County to ensure the long-term sustainability of the DSRIP investments. This will include the development of a multi-year roadmap for comprehensive payment reform and address policy and system barriers as we shift from volume-based care to value-based care. They will ensure the increased value to patients, providers and payers across the spectrum, not just those within the Medicaid system, ensuring the sustainability of these transformations beyond MTP.

Workforce Development Workgroup will be comprised of cross-sector partners with workforce development expertise. Members will scan and assess the local workforce environment, identify barriers to implementing chosen projects, work with state and local subject matter experts to propose investments and initiatives that address gaps, and identify policy and system solutions. The workgroup will work closely with the Strategic Improvement Team and the Quality and Continuous Improvement Workgroup to support partner groups with training and coaching, partnership building capacity, and problem solving and will report their findings to the CVC, PIP, RHIP and the Board.

HIT/HIE Workgroup will be comprised of CIO/CTO level experts and participating providers. This workgroup has the oversight of the HIT/HIE work plan for the region. They will ensure that expenditures requested to fund and support HIT investments are presented to PCACH Leadership, including rationale for expenditures provided to the Waiver and Investments Committee and the Board. This workgroup is responsible for the coordination of HIT/HIE related efforts across various agencies and organizations in the region. This workgroup will be led by the PCACH chief information technology officer (CITO) and will prioritize new initiatives such as EHR installations, interfaces, and other investments for the region.

Quality and Continuous Improvement (QCI) Workgroup will be comprised of clinical transformation experts and leaders including large and small providers to monitor continuous quality improvement, program management and overall success of meeting clinical outcomes and care delivery redesign. The QCI Workgroup will partner deeply with the DLT and the SI Team, utilizing the self-monitoring tools and resources that drive transformation across the care settings. This workgroup, led by the PCACH Director of Strategic Improvement, will report their findings to the PIP, CVC, RHIP and then to the Waiver and Investment and Executive Committees of the Board before final review and approval by the Board. This workgroup will include focused evaluation for specific innovative changes across care settings.

Operational Support Team

Strategic Improvement (SI) Team will be comprised of transformation coaches based in PCACH to provide direct coaching and technical assistance to MTP participants for improved region-wide quality, efficiency, and effectiveness of care processes. This is an internal team that provides external services to support our regional providers and partners participating in the MTP.

Five Required Domains

Financial

Decisions about the allocation methodology, roles and responsibilities of partnering providers and budget development.

- Internal capacity provided by CFO, senior fiscal analyst and administrative accountant

- The CFO provides experience as a;

  - Licensed CPA in the State of Washington

  - Member of Healthcare Financial Management Association (HFMA)

- Financial Committee of the Board

- Waiver and Investment Committee of the Board

- Contracts with partnering providers will be based on the Transformation Rules of Engagement, provide clarity on the roles and responsibilities of the parties, have breach, cure, and termination provisions, and will provide terms and conditions on which they will earn incentive payments (contracting to take place in early Q2 of 2018)

Clinical

Appropriate clinical expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban and rural providers.

- Internal capacity provided by CEO;

  - Fellow of the American College of Healthcare Executives, 2016;

  - Certificate from American Hospital Associations "Health Care System Transformation Fellowship" 2012; and

  - Certificate from IHI Open School for Health Professions (Quality Improvement, Patient Safety, Leadership, Patient-and Family-Centered Care, and Managing Health Care

Operations), 2013

- o Led a Strategic Partnership with former employer and the Institute for Healthcare Improvement – one of only 16 partnerships worldwide at the time
- Planned addition of part-time medical director
- PIP, including the experience of Dr. Huang (Chair) in Oregon State; Dr. Sam Huber (Chief Medical Officer of Behavioral Health, MultiCare) in New York State (both 1115 Waiver states); Dr. Dimitry Davydow MD, MPH FAPM (Vice Chair); (Medical Director of Behavioral Health, CHI Franciscan Health System, St. Joseph Medical Center) in Collaborative Care Model design and implementation, with University of Washington AIM Center.
- Quality and Continuous Improvement Workgroup

Community

Emphasis on health equity and a process to engage the community and consumers.

- Internal capacity consisting of Community Engagement Coordinator and Senior Director of Partnerships, Policy & Equity and a Senior Advisor of Applied Research with deep experience in Community Health Workforce development, equity, community engagement strategies and partnership development
- CVC

Data

Processes and resources to support data-driven decision-making and formative evaluation.

- Internal capacity supplied by Strategic Improvement Director
- Internal capacity supported by Chief Information Technology Officer
- Internal capacity supplied by Data Analyst
- DLT
- HIT/HIE Workgroup
- Contract with CORE
- Contract with CCS

Program Management and Strategy Development

Organizational capacity and administrative support for regional coordination and communication.

- The PCACH organizational and staffing structure (Attachment 201) supports our interconnected governance and organizational capacity.
- Currently PCACH has a CEO who is responsible for oversight and accountability, reporting directly to the board. She is actively engaged in leading the regional strategy, coordination and communication through the community-led shared learning and action vision. The CEO, COO/CFO and newly- hired Strategic Improvement Director have experience with improvement science (i.e. CEO previously led a strategic partnership with the Institute for Healthcare

Improvement for a regional community and health system for several years). The Strategic Improvement Director and newly hired Director of Health Transformation are responsible for successful relationships, communication, coordination and accountability among diverse providers and partners. PCACH capacity is evident by the background of the COO/CFO; shared CITO; Director of Partnerships, Policy & Equity; Community Voice Coordinator; Program Manager, Pathways; Clinical Manager (hiring in progress); Senior Financial Analyst; Manager of HR and Operations and newly- hired Manager of Governance and Executive Office. We have also deepened our bench strength in the area of communications through the expanded roles of the communications specialists to clearly defined roles of Manager of Marketing (including social media) and Manager of Communications to ensure that our shared learning infrastructure is intact, transparent and accessible to all members of Pierce County. As the work evolves this next year, PCACH has plans to hire several Improvement Advisors that will be serving to support providers and partners in their practices and organizations, a data analyst, a senior advisor in applied science to support community engagement, equity, tribal relations and workforce and we are seeking to share a Medical Director to support the clinical – community linkages. In addition, we have contracted for strategic support from subject matter experts in the areas of public/private partnerships; public and healthcare policy and systems change; data analytics and evaluation; and authentic community engagement / health equity.

- The workgroups outlined in our project plan include our Strategic Improvement Team and the Data and Learning Team that provide critical expertise and operational mechanisms to the overall shared learning and organizational capacity of the PCACH plan.
- Governance and operational mechanisms outlined above creates an integrated structure, that builds coordinated capacity for accelerated care and payment transformation, ambitious healthy equity agendas, and sustainable healthy communities. The staff and teams/workgroups outlined above provide a unique function that allows the interconnected governance to make informed and sound decisions. A key challenge for these emerging partnerships is managing the interaction between different modes of governance, and partner interest, which at some points may generate competition. As you can see the organizational capacity sets a range of checks and balances to overall transformation accountability, deep community engagement, our laser focus on addressing health equity and supporting change management and process and quality improvement. To highlight one of those checks and balances please see the Strategic Communications Plan and Matrix. (Attachment 202)
- Organizational capacity is fully developed for our current state and is staged to evolve as we move into additional phases of the work. PCACH has been strategic in the development of our capacity and administrative support model with a robust organizational plan. Please review attached Strategic Communications Plan and Communications Channel & Matrix (Attachment 202) that was attached with original submission. PCACH has a well-developed organizational structure with current, future and projected support as the work evolves.

Partnering Provider Participation and Performance

PCACH has developed provider expectations, initially through the regional adoption of the Rules of Engagement, that will be followed by a contract with participating partners and providers during the implementation/action development phase. PCACH is currently developing a contract which will further

clarify our oversight structure and the participation guidelines/scope tied to partnering provider participation and performance. Depending on whether a provider/partner formally ends their contract or is negligent in their contractual obligations, interventions and opportunities to resolve issues will guide the process. PCACH will have contracts in place to ensure scope and terms are clearly outlined during the spring of 2018. If a provider is negligent in contractual obligations, as outlined and monitored through our previously developed and adopted Rules of Engagement, monitoring and payment tied to reporting (Milestones) and Performance Metrics, and Quality Improvement Plans will guide the process. Pierce County ACH will do the following based on the contract failure and willingness of provider/partner to remedy issues:

- withhold payment;
- provide technical assistance to improve the providers performance and to address barriers to re-engage the provider/partner;
- adjust the contract to reduce expectations to keep the provider/partner engaged;
- have a "cut off" point where a provider is no longer in contract with Pierce County ACH;
- continue to invite that provider to the table to participate, although they are no longer contracted with Pierce County ACH;
- allow that provider/partner to re-engage at a later time in the Demonstration.

The ultimate goal of Pierce County ACH is to help providers/partners move along the care continuum, transition from volume to value and meet the Quadruple Aim supporting health transformation. PCACH we will put contracts in place to guide the process and will provide regular points for remedy of contract compliance issues with low performance and/or failures from lack of robust or complete lack of participation.

Table 5. PCACH Roles & Responsibilities (RASCI)

PCACH Roles & Responsibilities (RASCI)					
Governance/oversight of the five domains					
	Financial	Clinical	Community	Data	Program Management & Strategy Development
ACH Leadership	R/S	R/A/S	R/A/S	R/S	R/C/I
Partnering Providers	S/I	R/S/I	S/I	S/C/I	C/I
Community Voice Council	S/I	S/I	R/A/S/C/I	S/I	C/I
Provider Integration Panel	S/I	R/S/C/I	S/C/I	S/C/I	C/I
RHIP Council	S/I	R/S/C/I	S/C/I	S/C/I	R/C/I
Waiver & Investments Committee	R/A/S/C/I	S/I	R/S/C/I	S/C/I	C/I
Finance Committee	R/A/S/C/I	S/I	I	S/C/I	I
Executive Committee	R/S/C/I	S/I	C/I	R/S/C/I	I
Nominating Committee	S/I	S/I	I	I	I
Board of Trustees	A	S/I	I	A/C/I	A/C/I

RASCI DEFINITIONS
Responsible   Who is assigned to do the work
Accountable   Who makes final decision and has ultimate approval authority
Supportive   Who can provide resources or can play a supporting role in implementation
Consulted   Who must be consulted before a decision or action is taken
Informed   Who must be informed that a decision or action has been taken

Phase II Certification Feedback

Opportunity to expand upon COI policy. Is there a mechanism for other parties (beyond the Board membership) to raise an issue?

To address the lack of specificity regarding Conflict of Interest (COI) beyond financial COI, PCACH's Board of Trustees adopted a Dispute Resolution Policy in August 2017. (See Attachment 10.) The policy outlines the mediation, arbitration, and litigation processes the organization will observe in the event of a dispute among participants in PCACH, disputes between one or more Participants and PCACH, disputes between PCACH and any Non-Participant person or entity. Beyond the Board, PCACH has open Board, Council, Panel and workgroup meetings and during each meeting has two times (at the beginning and the end of each meeting) for public comment. It is communicated to the public and community that we encourage anyone that believes that there is a conflict, or a potential conflict raise the issue in the public forum, so the board can listen and then make determination prior to vote. We also provide for all community members to communicate with PCACH via our website, email and in person meetings.

Community and Stakeholder Engagement and Input

PCACH's community engagement approach has been to create a system with community voice embedded throughout our shared learning infrastructure, while demanding a health equity lens for all decision making. Such a system enables learning and acting together as one, not only in choosing, designing and implementing our Medicaid Transformation projects, but in all the work of PCACH. We see this work as addressing up-, mid-, and down-stream issues across our region so all residents have access to equitable care and equitable, improved health outcomes. Therefore, we have created a system that engages community voice not in a silo, but as a foundational requirement for the success of PCACH.

At the center of our community engagement system is the Community Voice Council (CVC). The initial round of CVC members was chosen intentionally for their lived experience and firsthand understanding of the difficulties in navigating the fractured healthcare and human services network of Pierce County. Since that round, CVC members have been responsible for vetting and choosing other members that represent diversity in race/ethnicity, age, gender identity, sexual orientation, disability, religion, payer status (Medicaid beneficiaries are on the CVC) and geographic location. A minimum of two CVC members are offered seats on all other PCACH governance councils and workgroups, which holds all decision-making bodies accountable to first listening then deciding. In this way, we create not only opportunities for engagement, but meaningful input that resounds across our shared learning structure. See Attachment 8, 9, and 11)

Robust Public Input into Project Selection and Planning

The CVC was convened in April 2017 and has met monthly to discuss project planning, community-based care coordination and the Pathways Community HUB model, ways to ensure authentic community engagement, and developed a work plan to address gaps in PCACH's outreach efforts. The CVC, with support from the PCACH Communications Team, developed a broad communication plan and community-relevant materials. They will use these materials to inform their own networks and identified networks about project planning and implementation efforts that will begin in earnest in 2018. (See Attachment 12.)

Additionally, the CVC has a direct line to the Board and holds a voting seat at the Board table. They contribute their knowledge and experience into the shared learning structure in the same way providers, payers, CBOs, etc. share their perspective and expertise.

Outside of the CVC, opportunities for input have been frequent. A major way PCACH has solicited input is through what we refer to as the Phase I Partner Inventory. The inventory was a 12-page document, exploring individual organization's interest and barriers to participation in MTP. The inventory was sent out in September 2017 to more than 70 different types of organizations, such as clinical providers, hospital systems, behavioral health providers, EMS, and community-based organizations. PCACH received over 30 responses, with approximately 10 from clinical providers and hospital systems, 10 from behavioral health providers and 10 from community-based organizations.

Additionally, please see our Governance section for types and frequency of meetings, rosters of attendance and minutes, which include public comment periods on the front and back end of each meeting. All monthly, occasional bi-monthly council, and workgroup meetings were and are open to the public, including a public call-in/web conference line, and non-Council member participants were and are invited to freely participate in discussions and provide feedback at meetings. Meetings are

advertised via the PCACH list serve, social media, on the PCACH website, and through requests to partners and stakeholders to share specific meeting information.

Frequency of Opportunities

Outside of the opportunities noted above, i.e. regular meetings (CVC and as noted in our governance section), call-in options for every meeting, web and social media presence, and the PCACH list serve, we have been approaching means and frequency for input in other ways.

First, we recognize that not all our CVC members or other members of the public have access to technology that allows them to receive materials via email, regularly check our website, easily print materials for review or record, or follow us on social media. Upon request, we will personally deliver materials to people's homes, make time for one-on-one phone calls or in-person updates and/or allow printing to occur here at our offices.

Additionally, we have been accessible for ad hoc meetings/presentations for organizations or collations that have already been gathering people together. This includes, as examples, presentations to the Pierce County Perinatal Collaborative, the DSHS/DBHR Behavioral Health Consumer Forum and Effective Outreach and Integration of Care for the Homeless Workshop (hosted by Washington Association of Community and Migrant Health Centers). Through these opportunities, our goal is to let the broader community know about PCACH, including our mission, vision and work, and ways people can participate or get additional information.

Broad Reach and Ample Response Time

PCACH recognizes it can be difficult to have truly broad reach and ample response time for community engagement. Barriers could include community members not being paid through an employer to attend meetings, leading to a lack resources, such as time, money or transportation, to devote to attending meetings or not knowing the unwritten cultural rules or language of committee meetings, decision making and governance bodies and therefore feeling intimidated or unsure about when or how to give honest input and ideas.

To ensure PCACH does not end up with tokenized engagement, we have resourced and structured our community engagement in the following ways:

1) **Staffing**: By staffing the CVC with a bicultural, bilingual, dedicated staff person we demonstrate authentic community partnership is worth our investment. This staff person supports all ACH members on learning and acting together, so the norms of one group do not overshadow and dominate another.

2) **Supporting CVC Leadership and Self-Governance**: The PCACH does not lead the CVC, CVC members lead the CVC. Dedicated staff supports, coaches and runs interference for CVC members, but does not impose the will of the PCACH on the CVC. CVC members developed their charter, established their meeting schedule, locations, agendas, and structure each meeting in ways that assure community members feel welcomed (e.g., by having food and child care).

3) **Stipends:** CVC members receive a monthly $75 stipend unless they opt out.

We see these decisions and the resulting structure as a long-term investment that do not often create a single opportunity for input or decision making. We use an iterative process for incremental change, where the conversations, recommendations and feedback of each council is shared across our shared

learning infrastructure and provided monthly to our decision makers and single point of accountability, our Board of Trustees.

Beyond the CVC, PCACH has worked to partner with other existing community networks:

1) Pierce County Community Health Worker Collaborative (CHW Collaborative):

PCACH is in the final stages of entering a formal relationship with the CHW Collaborative to mutually benefit and further each organizations' work. The intention of the relationship is for the CHW Collaborative to connect community health worker's voice to system reform and further PCACH work, communication and feedback into communities otherwise inaccessible to PCACH due to reasons of trust, lack of knowledge or cultural appropriateness.

2) Emergency Medical Services:

Five fire jurisdictions within Pierce County are actively involved in project planning for PCACH through individual jurisdiction meetings, sector work sessions and council/panel/workgroup meetings. These five fire jurisdictions serve approximately 692,000 of the approximately 850,000 residents of Pierce County that includes a geographic area from Eatonville to Bonney Lake to Steilacoom. These efforts give us another unique opportunity to deepen our community engagement reach, as community paramedics are trusted and welcomed into some of our most vulnerable populations' homes. Because of this access, community paramedics, even with their current, limited scope, know more about some of our community's most vulnerable than any other provider.

Transparency

PCACH posts all council, workgroup, and board meeting agendas, materials, and minutes on its website for public viewing. The logic and rationale for decisions can be seen from these materials. Concerns and questions are addressed by PCACH staff through follow-up with the intent to understand the concern/question, and then referred out to the appropriate workgroup, committee, and/or governing body for further discussion.

Addressing Concerns and Questions from Community Stakeholders

- **Public Comment:** One concern that came from the community was ensuring there was adequate time for the community to provide input at each meeting. In response we have put public comment at the front and back of each meeting.

- **Networking Time:** Partners and stakeholder wanted more networking time. In response we have built in networking time during key meetings and work sessions. This allows for new partnerships, alliances and learning opportunities.

- **PCACH Structure:** The community was worried that each working group and council could become siloed as the work speeds up and moves towards implementation. Based on that feedback, we have placed representative liaisons to each workgroup, council, and board. This supports continuity and shared learning across groups.

- **Community Voice Council:** The CVC wanted Executive Leadership to support their involvement and direction. In response, the CEO of the PCACH meets with the CVC as requested to further support community voice and power.

Three Elements of the Project Plan Shaped by Community Input

1) **Transformation Rules of Engagement:** This collective agreement by and for providers was created by the PIP, during open evening meetings, with dinner provided for all in attendance, and our standard public comment periods at the front and back end of the meetings. The RHIP Council reviewed and added elements, specifically the ASQ screening tool and "one key question." It is based on community input and Board recommendations, that while PCACH is officially submitting four projects under MTP, the Transformation Rules of Engagement ensure the integration/inclusion of Oral Health, Maternal Child Health, Transitions of Care, and Diversion strategies. See Attachment 13 and 14.

2) **Community-based Care Coordination:** The CVC provided direct input on the target population for our pilot HUB and were included in the process for selecting Care Coordination Agencies. The Care Coordination Advisory workgroup and a public comment period shaped the RFP for selection of CCAs.

3) **Emergency Management Services:** Engagement with EMS has led to the current models of care, which ensures projects integrate outside of the clinic walls to support primary care services, hospital-based care, behavioral health, home health, skilled-nursing care, housing, and social services while ensuring identified community needs are met.

Continuous Engagement

PCACH strives to recognize and honor the unique history and culture of Pierce County. We believe that by being aware of our community's history and culture—both the bad, which could include income or racial segregation, poverty, or crime, and the good, which could include resiliency and community-led efforts—we will authentically bring the community's voice to all our work. This community voice, and the wisdom behind it, knows the strengths, needs and potential solutions of and for Pierce County. This voice shapes both the community feedback to the policy makers and system leaders and maybe more importantly, the community response to the actions taken by those with power. The CVC designed their own workplan for going into much of underserved Pierce County and how to create the trust necessary for inclusion of diverse voices within PCACH.

Our vision states that we are community driven in our shared learning and action. As a part of our deep commitment to authentic community partnerships and our determined focus on infusing equity into all our work, PCACH has three goals for our community engagement work: 1) community voice is embedded into our shared learning infrastructure, 2) CVC membership includes representation from a broad range of underserved populations, and 3) CVC members routinely reach out to community members for their recommendations and feedback.

The CVC updates their outreach, membership and strategy goals to assure inclusion of underserved populations into all PCACH's work and decisions. The CVC collaborates with the Data and Learning Team (DLT) to identify underrepresented populations who need additional outreach to and representation on the CVC Council. Because the demographic data available to the DLT is often based on zip code or census tract data that prevents a nuanced understanding of the population, CVC members' also interview community members and representatives of community- based organizations to refine their understanding of new voices that need to be incorporated into the CVC.

The CVC also holds quarterly community listening sessions to provide information to the community and

to get feedback about and suggestions from the community. These listening sessions create an iterative process between the ACH and the community, increasing the likelihood that the ACH will deeply understands the needs and feedback from the community. The CVC will work closely with representatives of the Community Health Worker Collaborative, trusted CBOs, and faith communities to include people who are often distrustful of mainstream organizations and systems in these listening sessions.

Our current governance structure is designed to ensure accountability to community and stakeholder feedback throughout transformation implementation and will not change. A minimum of two CVC members are offered seats on all PCACH governance councils and workgroups. They also have a voting seat at the Board table. Through this structure CVC representative liaisons share community recommendations and feedback across our shared learning infrastructure. In the coming year, PCACH expand the shared learning infrastructure offering seats on the CVC to representatives of the other Councils.

Local Government Engagement

The CEO of PCACH knows the importance of local government in the selection and implementation of MTP. She has worked tirelessly at building these relationships and education of our elected officials on what is an ACH, what is MTP and the role of our elected in our regional public-private partnership. This includes work with our county executive, our county council, and Senator Steve O'Ban. In particular, it is the work of our CEO and the resulting relationships that sparked the Pierce County executive and council to move to FIMC. County Council Member Derek Young sits on the Opioid Taskforce, Senator O'Ban sits on our Board and chairs the Waiver and Investments Committee, and other county officials, such as Carol Miller, sit on other councils.

Phase II Certification Feedback

Opportunity to formalize the inclusion of social health/CBOs as formal partnering providers.

PCACH believes that without integrating the social determinants of health into our work, we will be unable to achieve the Quadruple Aim (see Theory of Action and Alignment Strategy). As such, the RHIP, Waiver and Investment Committee, the Care Coordination Advisory and Opioid workgroups, all have social health and CBOs involved (see Governance for rosters). Additionally, PCACH sent out approximately 70 Phase I Partner Inventories to a broad range of partnering providers. Of the roughly 30 that were returned, 10 represent community organizations, such as First5Fundementals and the Perinatal Collaborative, which in and of themselves are coalitions made up of large numbers of social service providers.

Tribal Engagement and Collaboration

Identification of Tribal and IHCP Priorities

At a Tribal-specific level, PCACH has worked on outreach to our two Tribal partners with land in the boundaries of Pierce County: the Nisqually and Puyallup Nations. We actively participated in our ACH-Tribal workshop hosted by the American Indian Health Commission (AIHC) and the Healthcare Authority (HCA), where we learned of some initial priorities from Jennifer LaPointe, Operation Director at Puyallup Tribal Health Authority:

- The current residency program at the Puyallup Tribal Health Authority and exploring ways to keep workforce local (Workforce)

- Sustainable care coordination to get current services being delivered paid for (Community-based Care Coordination)

- Initial interest in consulting at some point on integrated payments payment (Bi-directional Integration)

Beyond that, we have worked at creating meaningful opportunities for engagement. We have sent formal letters, both electronically and hardcopy, as well as board materials and invites each month to both chairmen and health directors of the two Nations. The Puyallup Nation has yet to respond. Recently the Nisqually Nation reached out, letting PCACH know they were working with Cascade Pacific Action Alliance (CPAA) and would not be engaging any further with PCACH.

The plan for the new year is to continue activities, with additional efforts to seeking engagement. Currently, PCACH has budgeted for and anticipates a 0.5 FTE Tribal Liaison position within our organization. A current consideration of PCACH is if we were to take the funds set aside for that position and give them to the Puyallup Nation for capacity building and ACH engagement. Of course, this idea needs review, consideration and approval from the Puyallup Nation, but is an example of how PCACH is considering new approaches towards engagement with Tribal Partners.

At a non-Tribal specific level, the PCACH, through conversations with HCA, AIHC, and various presentations or educational opportunities, have identified the following considerations that will inform our engagement efforts and project planning/implementation moving forward:

- The Federal trust responsibility and the legal obligation of the Federal government to provide healthcare for all American Indians/Alaskan Natives and how the MTP intersects and interacts with the relationship between Indian Nations, the state government and Federal government, including the role ACHs play

- Data, both access to and "ownership" of the data, based on the historical context of how data has been obtained and used to marginalize or eradicate certain populations

- Culturally-specific, responsive and authentic behavioral health interventions, as AI/AN populations see some of the largest disparities in behavioral health outcomes, which comes from intergenerational trauma and high levels of adverse childhood experiences (ACEs)

PCACH recognizes that we do not have the solution to these problems and/or considerations, but we can be sensitive and responsive when working towards project implementation. We welcome input and/or feedback to adapt this list as we build more collaborative relationships with Tribal partners.

Priorities and Projection Selection and Planning

During our ACH-Tribal workshop, PCACH leadership, including the PCACH Board Chair, learned of the long history the Puyallup Nation has with care coordination, bi-directional integration of care and an established residency program. As such, these three specific items informed our approach in the areas of workforce, care coordination and di-directional integration.

Attendance at the ACH-Tribal workshop informed PCACH's approach to project planning in the following ways.

- First and foremost, PCACH recognized that the Puyallup Tribe has tremendous expertise in care coordination, bi-directional integration, workforce development and other areas essential to project planning and implementation. We learned during the workshop that the Tribe is willing to guide PCACH in these areas and to share what they have learned. While the Tribe has not selected a representative to sit on PCACH's Board of Trustees, we have had Tribal representation at the workgroup level and are working to strengthen relationships and trust as a necessary precursor to more formal engagement.
  During the workshop, the Operations Director for the Puyallup Tribal Authority, identified the Community Pathways HUB as a mechanism to assist the Puyallup in paying for care coordination services the Tribe already provides. The Puyallup has undergone considerable growth in recent years. PCACH is interested in learning more about how Pathways can help Tribal providers work at the top of their license, easing workforce shortages in their primary and behavioral health clinics, and provide culturally- appropriate care management for their members. Early ideas about how to achieve this included the possibility of creating a Pathways HUB.
- Operated by the Tribe or hiring a Tribal Clinical Manager for the regional HUB. These options are currently under consideration and will gain definition as we go into planning and implementation.
- As PCACH's workforce development strategies take shape over the next 6-9 months, we will consider conversations we had at the Tribal workshop about ways to retain the Puyallup Tribe's behavioral health residents within the region. Assistance with loan repayment was one option discussed. When the Workforce Development workgroup convenes in the spring of 2018, PCACH will invite Jennifer Lapointe to sit on that body or to provide subject matter expertise regarding strategy development and Tribal considerations.

Recent conversations with the Tribal Liaison for Molina Healthcare, have been very helpful in identifying next steps both in strengthening our relationship with the Puyallup Tribe and in helping to inform PCACH's project plan with Tribal- specific considerations.

- The Tribal Liaison has made introductions between PCACH, the Salish Puyallup Cancer Clinic, and the Puyallup Kwawachee Counseling Center. We hope to be invited to attend the drumming circle at the counseling center and to establish a relationship with the leaders of the clinic. We also hope to identify areas of potential partnership and opportunities to learn together as the counseling center and the cancer clinic consider integration to better serve cancer patients with behavioral health challenges.
- Under development at Molina is a Tribal-centric framework for integration focused on the needs of each individual Tribe. When that document is ready, PCACH will consider including it in the Transformation Rules of Engagement for bidirectional integration.

- The Puyallup Tribe is hosting this year's Canoe Journey in July and August 2018, called the Power Paddle to Puyallup. PCACH representatives have registered to volunteer at the event and will invite Tribal members to share information about the Canoe Journey with our Board of Trustees and Councils.
- PCACH is currently reviewing the Tribal Coordination Plan for MCOs as a guide for ensuring culturally appropriate care and imbedding cultural humility training into PCACH's care coordination approach. This and other guides, such as the report to the legislature regarding Tribal Centric Behavioral Health, will be used to further develop PCACH's equity framework. This framework will also be used by the Strategic Improvement (SI) Team to ensure an equity lens is imbedded in the transformation work at the practice level.

Regarding the non-Tribal specific consideration, PCACH has been most focused on the selection and establishment of the cornerstone work related to the development of the Pathways Community HUB. This model offers an intersection with Tribal Partners, but also necessitates important considerations related to the data that will be collected and reported through the HUB technology platform. We have been sensitive to this consideration by engaging with state-level partners to consider the potential of establishing a population-specific HUB. Dr. Sarah Redding, founder of the model and providing technical assistance to PCACH, has indicated that this could be an option. In this way, an organization or agency selected by Tribal Nations across the state, could serve the function of the HUB and "own" the data generated on clients within the model, including Pathways outcomes and health outcomes.

Another consideration of PCACH has been the establishment of the Transformation Rules of Engagement and the requirement of a "trauma-informed lens" required across all settings. PCACH recognizes this is a lofty goal and one that is difficult to hold providers accountable to, but we would also welcome partnering with or supporting Tribal health services on providing education or technical assistance to providers in the greater Tacoma/Pierce County area around more culturally-specific or culturally-aware care.

Statements of Support

PCACH has not received any statements of support from Indian Health Service, tribally operated nor urban Indian health program (ITUs) in our region. We have been working to build an initial relationship with the Tribes and continue to reach out through the respectful state recommended approach.

Phase II Certification Feedback

PCACH's Executive Committee is serving in the role of Tribal Implications Committee as PCACH has not secured formal engagement from Tribal Governments in our region. The Executive Committee's consideration, as the Tribal Implications Committee, regarding the formation of this committee is to not move forward without input from the Tribal Governments, hence they will continuously serve this role until we have engagement from the Tribes. PCACH strives to meet not just the letter of the Tribal Collaboration and Communication Policy, not also the spirit and intent, which is why we have not formed a specific Tribal committee without Tribal input.

Opportunity to better emphasize attempts to engage tribes in project plan development.

PCACH has sought all available opportunities to engage tribes in our project plan development including respectful communications as recommended from our Tribal education sessions that included our

Board, Councils and staff. PCACH has tried to take the most respectful and culturally appropriate approach to creating a relationship with Tribal Partners in our region. As such, our attempts at engagement have been directed towards the Chairmen of each Nation. We believe it is their responsibility to allocate their national resources to engagement as they deem appropriate.

Recommend Tribal representation on its Board.

PCACH is actively seeking and would like to see tribal representation on our Board. We will continue to hold open our Tribal-designated Board seats and include Chairman Bill Sterud and Executive Director of the Puyallup Tribal Health Authority Chris Henry, on all communications sent out to Board members. We are taking into consideration how to approach the Puyallup Nation in the new year regarding involvement and are open to suggestions, feedback and advice.

Funds Allocation

Manage Funds Flow

With input and direction from its workgroups, CVC, RHIP, Waiver and Investment Committee and Board, PCACH developed funds flow guiding principles:

Table 6. Guiding Principles

GUIDING PRINCIPLES	
Flexible	Able to flexibly change over time, by partner size and accepted project risk
Equitable	Balances equity and fairness to all partners with intended impact
Locally Responsive	Meets the needs of the locality even within the same provider (i.e. urban vs rural)
Compliant	Meets criteria in the Special Terms and Conditions (STCs)
Simple	Transparent and clear methodology that is easy to understand
Collaborative	Motivates and encourages partnerships and the right behaviors
Sustainable	Promotes long-term transformation

The Waiver and Investment Committee (as described in our Governance Section) plays the role of managing our funds flow process. They will be responsible for creating recommendations relating to allocations, investments and oversight of the long-term PCACH strategy to invest in up-stream, social determinants of health through the Community Resiliency Fund.

PCACH, in consultancy with KPMG, has created an initial funds flow framework and detailed Excel-based funding model. The model was based on guiding principles established by the Waiver and Investment Committee (W&I) and approved by the Board of Trustees. The W&I is comprised of primarily independent members with representation from the business community, MCOs (executive level), health systems, community-based organizations and County government. The Committee is the primary work group responsible for finalizing the framework for funds distribution and reviewing and recommending periodic payments to partners under this model. The committee meets regularly and, supported with information provided by the CEO, CFO, and outside experts as necessary, is the governance body tasked with oversight and fiscal responsibility for all revenue and distribution streams. Their recommendations are reviewed by the Finance Committee and the Executive Committee before ultimately going to the full Board for final approval.

This committee is also responsible for managing the funds allocated to the Community Resiliency Fund. Although, we do not expect to launch projects out of this fund until 2019, the W&I will establish the charter and operating policies and create the ongoing strategy for the fund during 2018.

Timelines for distributing funds to partners will be established and publicly communicated. PCACH will

generally follow the HCA schedule for funding the ACHs, although fixed payments and specific investments in regional improvements may be approved and distributed in the demonstration years.

Roles and Responsibilities in Managing Funds Flow

Table 7. Roles and Responsibilities for Managing the Funds Flow Process

PCACH Roles & Responsibilities (RASCI)				
Managing the Funds Flow Process				
	Set Policy	Funds Allocation Strategy	Clear & Concise Information Requests	Checks & Balances
ACH Leadership	R/S	R/S	A	R
Partnering Providers	I	R/S/I	S/C/I	S/I
Community Voice Council	S/C/I	S/C/I	S/C/I	R/S/C/I
Provider Integration Panel	S/C/I	S/C/I	S/C/I	R/S/C/I
RHIP Council	S/C/I	S/C/I	S/C/I	R/S/C/I
Waiver & Investments Committee	R/S/C/I	R/S/C/I	R/S/C/I	R/S/C/I
Board of Trustees	A	A	I	A/C/I

RASCI DEFINITIONS
Responsible   Who is assigned to do the work?
Accountable   Who makes final decision and has ultimate approval authority?
Supportive   Who can provide resources or can play a supporting role in implementation?
Consulted   Who must be consulted before a decision or action is taken?
Informed   Who must be informed that a decision or action has been taken?   PCACH 11.14.17

Stewardship and Transparency

PCACH intends to use the funds flow guiding principles (Table 6), coupled with checks and balances from our shared learning structure to ensure proper stewardship of all DSRIP incentive funds. The Board has established initial policies and governing approvals which has set the roles and responsibilities of the Waiver and Investment Committee.

PCACH will prepare and disseminate biannual reports and dashboards detailing its success in meeting pay-for-reporting/pay-for-performance measures, VBP incentives and the associated amounts of incentives earned. We will also report the amount of incentive payments to each partnering provider. This information will also be available on our web site and shared publicly through our communications team.

The Board has approved the PCACH Accounting Policies and Procedures and Executive Limitations. These policies and limitations are designed to provide guidance and oversight over the fiscal affairs of PCACH, to ensure compliance with Federal and State regulations and sound governance principles, and

to minimize financial risk. All policies are structured to achieve the goals that assets of the organization are safeguarded, that funds are used for the purposes and under the guidelines for which they were intended, and that the financial position of PCACH is managed and reported accurately and transparently.

PCACH has developed a detailed operating budget which aligns with the funding and expenditure categories from the budget templates that were provided with Phase I, Phase II and Project Plan certifications. The 2017 budget was previously approved by the Board of Trustees in June of 2017. The 2018 operating budget, which was created as part of our detailed funds flow modeling work and which aligns with the planned use of project incentive funds as reported in the Supplemental Workbook, was approved by the Board of Trustees on November 20, 2017 after detailed review and recommendation by the Finance Committee. Each month, actual financial results are reviewed by the Finance Committee against the approved budget.

In addition to many years of healthcare financial management experience, our CFO has eight years of experience as a senior manager of audit with a national CPA firm, and was licensed as a practicing CPA in the state of Washington for 20 years. She reviews all contracts, which are signed by the Chief Executive Officer. Operational expenditures are also all reviewed by the CFO prior to check signature by the Chief Executive Officer or the Senior Director. New contracts for services or activities outside of the budget require review and approval by the Finance Committee and the Board prior to inception of any work. We believe these internal controls provide the necessary accountability and fiscal stewardship of the funds.

Significant Changes from Phase II in Additional Funding

In the budget and funds flow section of Certification Phase II, it was noted that we did not submit our financial statement, our financial statements were included in our original attachments. It was also noted that additional detail regarding health system partner investments would be appreciated. The two health systems in our region (CHI Franciscan and MultiCare) and one of the five payers, United Healthcare Community Plan, provided financial donations to support the development of PCACH's infrastructure, including the build of our community engagement system strategy and deployment. The two health systems provided approximately $180,000 in cash plus in-kind resources that include: legal, financial and original office space to formalize the structure of PCACH. Our Phase II budget included anticipated Year Two, SIM funding to be used to supplement efforts impacting social determinants of health that may not have been immediately addressed through MTP projects. Based on recent information about reductions in state funding, we no longer anticipate these funds being available to us. We continue to solidify relationships with agencies across the state to align social service resources with our project work and have agreements for in-kind resources to support our community health worker workforce development, supported employment services, and to assist in operationalizing our regional strategic improvement initiatives.

Project Design Funds

To date, PCACH has used project design funds to:

- Build organizational infrastructure;

- Further develop and implement a robust governance structure;

- Develop human resources and systems to hire and retain excellent team members;

- Hire and train team to support the work and community;

- Provide Professional Development for team and community partners;

- Establish framework to ensure equity, diversity, inclusion on the team, at both the governance level and throughout workgroups;

- Rent office space;

- Purchase office furniture;

- Purchase computers and IT equipment;

- Rent meeting space;

- Travel expenses for the work;

- Pathways Community HUB (Technical assistance, consulting)

- Procure legal and accounting services;

- Procure strategic consulting services;

- Develop our "Community Driven Strategy for Shared Learning" to meet the Quadruple Aim;

- Develop and conduct a Phase I partner inventory;

- Develop the initial Phase II partner inventory/assessment;

- Develop the Transformation Rules of Engagement;

- Develop and implement a communications plan and will continue to deepen our community outreach and engagement;

- Build out our data and analytic capacity;

- Develop initial framework for implementation project design plan;

- Develop the framework for Science of Improvement which includes the Strategic Improvement Team (internal) and Quality and Continuous Workgroup (external partner-driven); and,

- Develop initial long-term sustainability plan.

Actual expenditures of project design funds to date, by general financial statement category, are:

Project Design Funds (expensed to date)	
ACH personnel expense	$ 343,407
Strategic consulting services	271,681
Development of funds flow framework	128,800
B&O taxes	91,439
Professional fees - legal, compliance and accounting	68,144
Data and analytics strategy consulting	49,331
Community engagement and capacity building	46,615
Office rent and facilities expense	43,804
Computer and office equipment	35,296
Training, convening and community meetings	28,764
Pathways HUB consulting	20,000
Other ACH admin and infrastructure	19,058
Recruitment, retention, and HR	8,638
Board and governance	5,675
TOTAL	**$ 1,160,652**

The Board of Trustees had originally approved utilizing the $6M in design funds in the following manner: $1M to PCACH to use for PCACH administration expenses and $5M to be utilized to assist providers in planning for and implementing MTP projects including:

- Convening provider, partner and community engagement, forums and workgroups;

- HIT/HIE;

- Training, technical assistance;

- Workforce development;

- Funds flow strategy and design;

- Development of integration framework;

- Development of Strategic Improvement toolkit, including Science of Improvement that includes improvement advisors to support practice transformation and change management;

- Health system regional asset inventory and capabilities assessment;

- Recruiting and building ACH infrastructure;

- Investment in care coordination platform;

- Pilot Project;

- Pathways workforce RFPs; and

- ACH and provider data capacity analysis and strategy work.

Upon the recent disclosure regarding the decrease in DSRIP funding, the Board approved a more intentional focus of transformation care and service delivery systems changes in the four prioritized

project areas, to safeguard all project areas in a sustainable manner.

Funds Flow Distribution

With input and direction from its workgroups, the community, and governance bodies, PCACH developed funds flow guiding principles (Table 4) and a funds flow framework which has been approved by the Board of Trustees.

PCACH also met with four Participating Provider Systems (PPSs) currently implementing a Medicaid DSRIP project in New York state. In sharing lessons learned, these PPSs were consistent on several points:

- Funds required for infrastructure and capacity building should not be distributed directly to providers, but paid by the DSRIP management entity;

- It is extremely difficult to estimate the needs and expenses of the work ahead (the known unknowns) while in the planning phase; and

- Ensure funds are nimble enough to address unintended gaps as transformation occurs.

The funds flow model PCACH developed will be refined and informed by the planning work we will be engaging in with our partners during the first half of 2018. Distributions are calculated in two ways:

- Fixed - based on non-performance related criteria such as participation, level of engagement and specific infrastructure needs; and
- Performance-driven - tied to HCA DSRIP pay-for-reporting and pay-for-performance measures and ACH-established quality and performance measures.

Depending on the measure, outcome-based performance distribution will be made based on attribution of Medicaid lives. Fixed payments will be allocated in several ways:

1) a certain portion to be distributed to all partners equally to incentivize engagement and participation in the planning and design of the projects;
2) distribution based on level of network participation to incentivize partnering and commitment to integration;
3) specific investments based on partner inventory needs and partner group project proposals. These could be partner-specific investments or group or region-wide investments that benefit many partners by adding capacity in the region.

PCACH anticipates that smaller providers and community-based organizations, while gaining a smaller share of outcome-based payments, will have a proportionately larger share of investment support in the form of training, technical assistance, and short-term resources to supplement expertise in areas such as billing processes and revenue/cost analysis, HIT/HIE support, payer contracting, and data analysis.

Based upon the guiding principles and the learning from New York, PCACH has developed a framework for funds flow process for distribution that initially allocates funds to one of four categories (Figure 17):

Figure 17. Project Incentive Funds (Y1-Y5)

Figure 17. Project Incentive Funds (Y1-Y5)
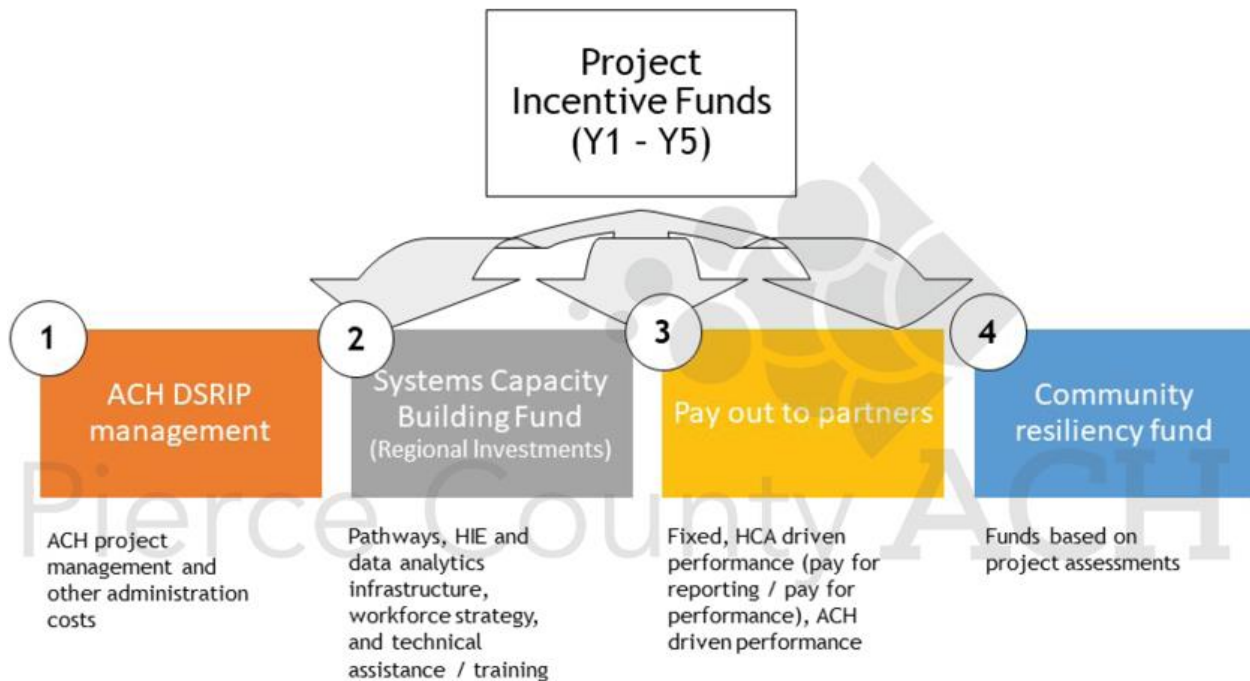
Updated: 11/09/2017

PCACH Management and Administration

The distribution of PCACH management and administration funds are managed and overseen by the Board via its annual budgeting approval process and expended pursuant to PCACH policy.

Community Resiliency Fund

PCACH plans to lead a collaborative process for developing a regional vision – a north star which will guide long-term investment to truly impact upstream issues. PCACH intends this work to further evolve with the goal of operationalizing in Q1 of 2019 to continue through the end of Q2 of 2020. This 18-month stakeholder engagement/coalition building process will provide a strong roadmap for the investments necessary to achieve PCACH's vision. Given the percentages allocated to the Community Resiliency fund, and the timing of the cash flow, we do not see significant accumulations in this category until the end of MTP.

Systems Capacity Building Fund

Waiver and Investments Committee recommends policies that govern the distribution of the Systems Capacity Building fund and will review expenditures proposed to be paid from the fund pursuant to the final approved policies.

Provider Payments

PCACH will work within the shared learning structure using the guiding principles, to further develop how funds will be distributed to partnering providers. We have finalized and adopted the Transformation Rules of Engagement and the initial Project Plan template has been drafted. Both documents will inform PCACH's reporting and performance metrics, which will further guide the model

design for distribution of the earned incentives going to providers. Input received thus far has focused on rewarding providers serving large numbers of Medicaid beneficiaries, those meeting and exceeding performance goals and unique partnerships with community-based organizations and local governmental agencies.

The specific percentages of total incentive dollars proposed across the 5-year MTP projects are illustrated in the table below (Table 8).

Table 8. 5-Year MTP Funds Distribution

	Y1	Y2	Y3	Y4	Y5	Total
ACH Admin	10%	7%	7%	8%	10%	8%
Resiliency Fund	10%	10%	10%	10%	10%	10%
System Capacity	52%	34%	34%	32%	31%	36%
Provider Payments	28%	49%	49%	50%	49%	46%

In conjunction with KPMG, who has previous expertise working with DSRIP programs and Waiver funding in other states, PCACH developed a model to calculate allocations of Project Incentive funds to all partnering organizations and PCACH across several use categories. Our methodology for allocation was driven by the principles described in Table 6.

We first estimated available funds based on Pierce County's Medicaid attribution and the number of project chosen. Projects were selected and are being designed based not only on ability to impact metrics and outcomes, but on impact to Medicaid beneficiaries.

We then factored in the costs for PCACH administration, including operating expenses of the ACH, support for governance, Pathways Community HUB administration and compliance activities. We estimated the significant investments required to achieve project success in our region which focus heavily on HIT/HIE/Population Health Management, workforce development, Pathways Regional HUB, and strategic improvement and quality improvement support. These investments are key to not only drive project performance, but to the success of building and sustaining system change, a strong workforce, and value-based purchasing across all partnering providers.

Provider incentive payments will be paid to traditional and non-traditional Medicaid providers and to Tribes. Various factors go into the calculation of these payments, including engagement and participation in project development and leadership; level of active participation in integration and partnering with other organizations; attribution of Medicaid lives; performance against reporting and project and quality outcome metrics; project cost; and support for uncovered services. Outcomes-based payments will be made to both traditional and non-traditional Medicaid providers. As we finalize our project implementation planning, we anticipate additional partners that are not traditionally funded by Medicaid to participate on our transformation of care and service delivery settings approach.

Our model specifically allocates 10 percent of all funding to our Community Resiliency Fund, which will be used to support partners not traditionally reimbursed by Medicaid. This fund will spearhead regional, community-led initiatives aimed at strengthening resilience in our community through social determinant investments, key policies and system changes for overall population health.

FIMC Attestation

Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
X	

Attest to whether the ACH region has implemented fully integrated managed care.

YES	NO
	X

If the ACH attests to having implemented fully integrated managed care, provide date of implementation.

NOT APPLICABLE

If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

January 1, 2019

Fully-Integrated Managed Care (FIMC) Incentive Funds

Pierce County government has submitted a binding letter and executed a contract with the Health Care Authority to move to FIMC by January 2019 as a "mid-adopter." PCACH's CEO has been working closely with Pierce County Executive and Legislative branches to encourage this move to financial integration which is necessary to support the clinical integration of physical and behavioral health in Pierce County.

We have a structure in place for these Incentive Funds to be allocated similarly to the project funds by using the same guiding principles as outlined in Table 5. There will be additional oversight and governance for half of the Incentive Funds. The Board approved allocating half the funds to sit in a reserved account for the Pierce County Governance Board, appointed by the County Executive, (PCACH's CEO has been appointed to this Board). This Governance Board will have oversight and support providers and county partners in the transition from the current Behavioral Health Organization (BHO) model to the future integrated financial model. PCACH has been learning from SWACH regarding their early adopter experience and from NCACH regarding their experience to date with the mid-adopter process. Based on those learnings, PCACH will be allocating dollars to support the transition by utilizing the internal SI Team to bring technical assistance and Change Management skills to support providers, as well as the county with infrastructure necessary for the transition. This includes funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care business processes. PCACH will be supporting the set-up required to support the providers as they transition to the FIMC model.

Required Health Systems and Community Capacity (Domain 1) Focus Areas for all ACHs

Capacity Building to Support ALL Projects

Capacity building in the three Domain 1 focus areas will support all PCACH selected projects by ensuring partnering providers have the necessary skills and infrastructure to transform care and service delivery settings to offer whole person care in a pay-for-value environment. The three Domain 1 focus areas are inextricably linked and together will provide a strong foundation for transformation efforts.

As highlighted in the PCACH Organizational Chart-Governance (Attachment 201) and the PCACH Strategic Improvement efforts that are currently under development (Attachment 206), PCACH intends to build a solid foundation to support providers and partnering organizations involved in transformation work in Pierce County. The Strategic Improvement Team will be deployed to support capacity and capability building with our providers and partnering organizations. PCACH will hire and deploy Strategic Improvement Advisors (IA) who will attend a 10-month Science of Improvement training program with the Institute for Healthcare Improvement that intertwines PCACH's transformation of care and service delivery settings and project portfolio to support regional projects and infrastructure development efforts. The improvement advisor programming places PCACH's projects into a rigorous improvement model that ensures capacity and capabilities are leveraged, built and deployed within the region with partnering providers to secure engagement and long-term sustainability. The four chosen projects and the remaining assimilated four projects adopted by PCACH governance, will be integrated into the IA programming so partnering providers have Science of Improvement methodology and infrastructure support wrapped around the interventions and innovations.

Necessary Investments and Infrastructure

PCACH has identified the following investments or infrastructure necessary to carry out the projects in domain 2 and 3:

- PCACH Administration
- Awareness and Sensitively Education and Training (cultural, equity, behavioral health)
- Training, Technical Assistance, Coaching
- Pathways Community HUB Technology, Training, Administration
- HIT/HIE/Population Health Management Systems
- Validated Screening Tools and Instruments
- Lost Revenue Support
- Data and Analytics
- Strategic Improvement Team
- Self-monitoring system
- Reporting platform
- Workforce

- Provider Engagement

- Partner Engagement

- Community Engagement

- Communications

PCACH intends to make the above-listed investments to support our partnering providers in transitioning to a value-based contracting environment where they will be paid for high-value, whole-person, integrated care.

- For partnering providers to successfully transition from fee-for-service to value-based contracting, specific capabilities will be required;

- Establish appropriate governance and organizational processes;

- Engage individual providers within their organizations;

- Develop care coordination and management;

- Develop and use technology and data analytics; and

- Develop links to address the social determinants of health.

Capacity building in the three Domain 1 focus areas will assist partnering providers in developing VBP capabilities and in offering whole-person care. For example:

- Investments in population health management systems will provide the capability to capture and analyze data for performance measurement and integrated care, care coordination and management, and links to social determinants of health; and

- Investments in workforce development will provide a path to governance and organizational processes, engaging with individual providers, care coordination and management, use of technology and data analytics, and links to address social determinants of health.

Value-Based Payment Strategies

PCACH knows these funds are temporary to support healthcare transformation. To make transformation sustainable, PCACH must ensure MCOs, as well as other payers—Medicare, commercial plans, large employers—are embracing alternative payment methodologies through value-based payment (VBP) to financially reward and sustain delivery system changes. Providers must make the transition from the First Curve, that of volume-based payments in the clinical setting, to the Second Curve, that of value-based payments.

First Curve to Second Curve through Transformation of Care and Service Delivery Settings

Volume-Based First Curve
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

THE GAP

Value-Based Second Curve
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

Source: Adapted from Ian Morrison, 2011.

Distribution of 2017 Provider Survey

PCACH supported and promoted the request to complete the 2017 Provider VBP survey by contacting providers in the region serving the Medicaid population and encouraging each organization to complete the survey in a timely manner. An email request was made to the ACH contact(s) in each organization asking them to forward to the appropriate department in the organization, and PCACH CEO followed up with a couple of emails and two phone calls to all the providers asking for their confirmation of submission. PCACH convinced several providers to complete the survey; the response rate was below our expectations as several of our providers shared barriers to filling out the survey, including technical difficulties and concern over sharing contractual details.

Current State of VBP with ACH Partnering Providers

The information shared with us during our Phase I Partner Inventory tracks consistently with the 2017 VBP Provider Survey. During PCACH's Phase I Partner Inventory and Guided Discussions, PCACH uncovered that several providers are in various stages of VBP/Alternative Payment contracting arrangements. A few providers referenced medium-to-full risk contracts in place for various populations they serve, with several sharing that their contracts are at various stages of value-based alternative contracting arrangements. A majority of the providers (especially our behavioral health and substance use providers) shared with PCACH that they do not have any VBP contracts. We understand that we have large gaps in the region and need to provide resources and capacity for providers to move into the VBP arrangements and to support them with practice improvement and change management, so they can move from volume to value payment models. There are a couple providers that have bi-directional integration in place and have contracts to match their evolving practices, but many need additional practice transformation support. PCACH will support their capacity and capability building with our Strategic Improvement team, plus leveraged and new resources. PCACH will be conducting a Phase II Partner Inventory and guided discussions to have a deepen our knowledge of the state of VBP with our providers. This will help inform resources brought into the region to support providers and MCOs.

Expectations Around Change

During our information sessions with providers, we have been reinforcing the VBP targets and MTP requirements contained therein. Providers understand the MCOs are required to move 90 percent of the dollars paid to providers into VBP arrangements, but their comfort level and understanding of how this will impact their practices varies greatly depending on practice size, sophistication of provider organization, and provider type. Behavioral health providers are most concerned with how VBP contracts will work as they are just adjusting to payment through the MCO and had not have experience with member attribution. Over the next 12 months, providers will look to PCACH to act as a convener and educator to help them understand the skills and capabilities they will need to be successful in a VBP environment.

Barriers and Enablers to VBP Adoption

Providers have shared a wide range of barriers; the following have been reported most often:

- Lack of interoperable health information systems;
- Lack of cost data to assess contracting arrangements:
- Lack of confidence in attribution of members;
- Lack of interest in accepting risk;
- Inability to adequately understand and analyze contracting arrangements: and
- Misaligned quality definitions and/or measurement, especially between Medicaid, Medicare, and commercial payers.

The MCOs have been a positive enabler towards VBP adoption thus far. They have been engaged and indicated a strong preference for working closely with PCACH to ensure providers have a better understanding of VBP and the skills, technology, and capabilities necessary to succeed in VBP contracting arrangements.

Regional Strategies

To date, PCACH has been collaborating with and providing presentations to regional MCOs and the Washington State Medical Association (WSMA), the Washington State Hospital Association (WSHA), Pierce County Medical Society, Washington Association of Community and Migrant Health Centers (WACMHC), to engage and educate providers regarding VBP and MTP. PCACH intends to undertake the following:

- Support FIMC progression in Pierce County (January 2018)
- Assess regional current state through Phase II Partner Inventory/Assessment (February 2018)
    - State of partnering provider capabilities and readiness
    - Gaps in partnering provider capabilities and readiness
    - Patterns: regional, provider type, provider size, provider payer mix
- Continue to work with local, regional and statewide associations and provider societies to educate and prepare for VBP (January 2018)

- Identify provider needs at regional level (March 2018)

  o Common gaps/needs

  o Most pervasive gaps

- Determine feasibility of broad-based solutions (April 2018)

  o Regional Solutions

  o Statewide/Multi-ACH solutions

- Develop strategies and plans to address needs/gaps (May 2018)

  o Leverage existing/developing resources

  o Leverage MCO and other payer programs

- Leverage DSRIP and other programmatic resources to support efforts (ongoing)

  o PCACH will use care and service delivery setting model to establish cohorts of providers based upon assessed VBP capabilities for shared learning

- Develop ongoing assessment mechanism (February 2018)

  o Partner with MCOs to develop tracking mechanism

- Monitor progress (ongoing)

Supporting Role for PCACH

PCACH will fill several roles in supporting partnering providers in the transition to VBP arrangements:

- Convener

  o Connecting partnering providers with one another, with new potential partners, with MCOs to find regional solutions

- Educator

  o Ensure partnering providers are aware of State's VBP targets and different VBP models;

  o Ensure partnering providers have access to resources and information on VBP readiness;

  o Ensure provider and non-provider partners understand capabilities needed for VBP; and

  o Partner with HCA, MVP, MCOs, and others to communicate changes and progress to allow PCACH to provide accurate and useful information.

- Developer of Regional Strategy

Through implementing the strategies listed above and partnerships with MCOs, HCA MVP, the Practice Transformation Support Hub, and PCACH's Strategic Improvement Team and VBP workgroup, PCACH will ensure partnering providers have access to training, coaching and technical assistance in developing the following capabilities necessary for success in a VBP arrangement:

  o Governance and Organization

    a. Leadership buy-in and organizational vision

- b. Workforce development

- c. Effective practice management system

- d. Revenue cycle management

- e. Performance management

- f. Legal evaluation and contract management

- g. Change management

- o Provider Engagement

  - a. Staff education

  - b. Provider network identification and engagement

  - c. Referral management

  - d. Engagement with and links to non-physician staff/ organizations

  - e. Co-location (if applicable)

  - f. Performance feedback and management

- o Care Coordination/Management

  - a. Single point of assessment

  - b. Coordination of care/services across specialties and sites of care

  - c. Development of comprehensive care plans

  - d. Patient engagement

  - e. Evidence-based case management

- o Technology and Analytics

  - a. Data aggregation

  - b. Data exchange and interoperability

  - c. Evidence-based population health management systems

  - d. Performance monitoring

- o Links to Social Determinants of Health

  - a. Patient social needs assessment

  - b. Knowledge of and access to services and organizations

  - c. Integration into clinical and care management protocols

  - d. Development of value case for addressing social needs

  - e. Social services referral staff/ programs

- Advocate for and Champion of Practice Transformation

- o Provide support to and advocate on behalf of partnering providers in context of developing VBP capabilities (e.g., support aligning quality measures or increasing access to data)
- Driver of Sustainable Reforms
  - o Support developing partnering provider capabilities without increasing overall system costs
  - o Ensure activities are in line with MCOs direction on VBP

PCACH's model of approaching projects as intertwined activities and interventions will align VBP strategies by transforming partnering providers individually as well as collectively. PCACH sees this as providing greater opportunity for the MCOs to more easily pay for true value. PCACH is very cognizant of the need to set expectations and criteria for performance in line with MCO direction, but also with the direction of other payers such as Medicare and commercial plans to avoid burdening providers with non-aligned expectations. Other strategies, such as grouping providers based upon their capabilities and goals will allow PCACH to align activities and strategies to create opportunities for shared learnings and grow the relationships among partnering providers.

Workforce Strategies

PCACH is mindful of the critical role workforce will play in successful transformation. Success with MTP will entail retraining the current healthcare workforce to function in a transformed, integrated system which pays for value rather than services. As has been mentioned, PCACH approaches MTP work from a care and service delivery setting approach. We will look at workforce needs, therefore, setting by setting and not project by project. We will look to identify specific ways and necessary capacities for building more efficient, effective care and service delivery settings, including the changes necessary to meet MTP outcomes for the selected projects.

PCACH will need to partner across sectors and settings to transform the current workforce, grow the workforce, both in existing and new roles, train the workforce for transformed care and service delivery, and improve workforce satisfaction to keep providers in their roles. Together, we will identify the workforce necessary to support payment and service delivery transformation activities and develop tailored plans to address the region's workforce capabilities, capacity, and gaps.

Local Residency Program: Within Pierce County, we hope to create a coordinated and common plan for building a pipeline for new primary care providers to work in Pierce County after finishing local residencies serving Medicaid patients. We would like to target local residencies:

- MultiCare Tacoma: 8 residents/year
- MultiCare Puyallup: 6 residents/year
- Puyallup Tribal Health Authority: 6 residents/year
- Community Health Care Tacoma: 6 residents/year

PCACH sees their potential role as partnering with the sponsoring agencies to build a common strategy to retain all the graduating residents each year. By creating a continuum of opportunities for graduating residents to continue in Pierce County, PCACH has the potential to address our primary care provider shortage serving Medicaid beneficiaries.

We plan to highlight those participants who are successful in the principles that connect with the Science of Improvement methodologies, including The Improvement Continuum. We then can attract, train, and retain skilled professionals and encourage payment mechanisms that support broader access to necessary services in traditional and non-traditional settings.

Additionally, PCACH will:

- Conduct a Phase II Partner Inventory to include a baseline readiness assessment across all clinical and community-based care settings
- Convene local resources and support their engagement in PCACH planning and deployment;
- Further advance relationships and coordinate with local health facilities, providers, employers, CBOs, MCOs, and other partners;
- Tailor Technical Assistance through the Strategic Improvement Team, Workforce Development workgroup and the Quality and Continuous Improvement workgroup.
- Use local expertise and available Technical Assistance, materials, and templates to develop PCACH specific plans;
- Identify PCACH-specific resource, Technical Assistance, and curriculum needs, requirements, and plans;
- Develop local deployment plan to address both short and long-term needs; and
- Other actions identified by PCACH, HCA, Workforce Subject Matter Expert's and ACH Collaboration.

Identification of Necessary Workforce

PCACH will identify the workforce necessary to support transformation activities by:

- Assessment and analysis of current data sources:
  - RHNI
  - Health Workforce Councils
    - Sentinel Network
    - WA Behavioral Health Workforce Assessment
    - Workforce Development Councils – statewide and regional entities, HPOG grants
- UW Center for Health Workforce Studies
  - HRSA funded Allied Health Workforce Research Center
  - Develop research and analysis of health workforce supply and demand
- Area Health Education Centers
  - Recruitment and retention strategies for rural/ underserved populations
  - Data support

- Department of Health Workforce Supports

    o State Office of Rural Health

    o Office of Health Professions–scope of practice, qualifications, WAC expertise

    o Topic expertise and targeted training resources

    o Community Health Worker training and practice integration

- Allied Health Center of Excellence

    o Connector between industry and the 34 CTC system colleges, HEET grants

- Practice Transformation Support Hub

    o Coach clinics and behavioral health agencies to extend social work, nursing and other professions skills to practice at top of the licensure and adopt team-based care

    o Workflow telehealth/telepsychiatry, clinical screening/tracking, care coordination, other new processes Support issues presenting barriers to practice transformation

- Inventory of Regional Provider Capabilities and Needs

- Compare Regional Needs with Needs of other ACHs to promote cross-region solutions

- Utilize the expertise of our Provider Integration Panel and other partners and stakeholders to assess potential activities and solutions

Early in 2018, PCACH will conduct a Phase II Partner Inventory / Assessment which will include a baseline workforce assessment across clinical and community-based care settings for each partnering provider. The Partnering Provider Assessment will deepen our knowledge of workforce capacity and gaps, allowing PCACH to tailor our assistance.

Consideration and Prioritization of Statewide and Regional Innovations

PCACH envisions prioritizing and utilizing all available statewide resources including guidance from Healthier Washington including the Elements of Workforce Planning[54] for training and technical assistance on integrated, whole-person care, team-based care, cultural competency, and health literacy. This strategy will allow us to make effective use of provided resources and more easily align with the other ACH regions across the state.

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[54]*Elements of Workforce Planning,* Healthier Washington, 2017.

Figure 19. Elements of Workforce Planning

Figure 19. Elements of Workforce Planning
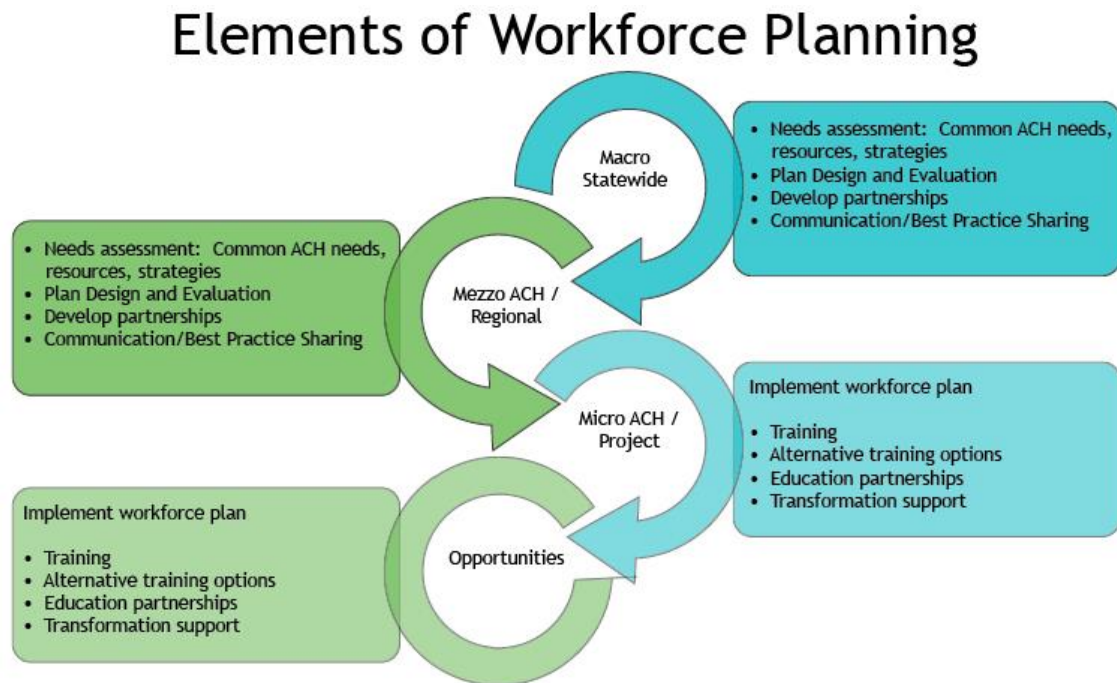
Source: Adapted from Healthier Washington

PCACH further envisions our PIP, regional clinical partners, RHIP and CVC in assisting us in developing regional workforce training and in understanding the level of education and comfort providers have with stigma reduction, trauma-informed care, and the elements of the IHI Workforce Model, "Improving Joy in Work"[55] intending this improvement framework to improve access to care and reduce provider burnout (Figure 19).

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[55] Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at ihi.org)

Figure 20. Improving Joy in Work

Source: Adapted from "Joy in Work", Institute for Healthcare Improvement. Updated: 11/09/2017
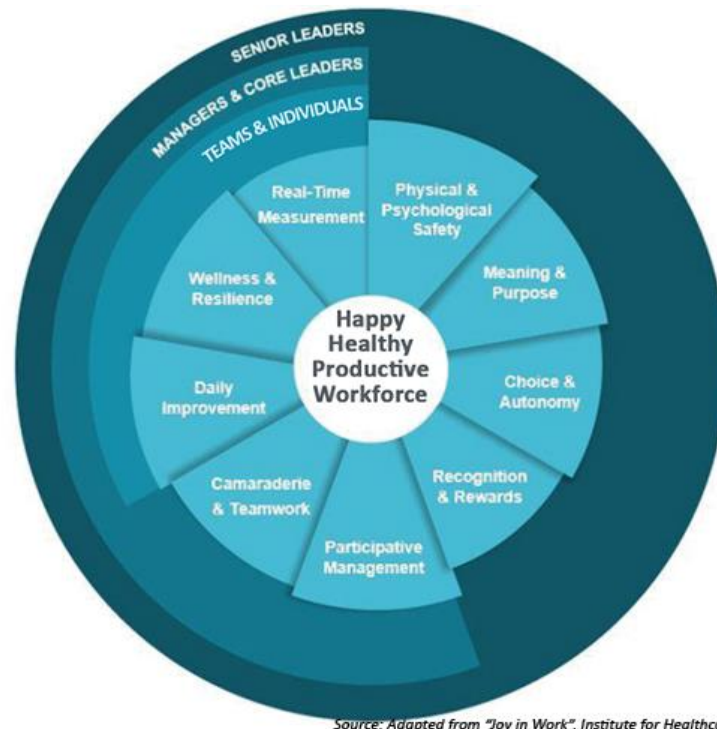
PCACH is further prioritizing the advancement of statewide and regional innovations to workforce capacity development by planning for an active role in the statewide workforce forum that will be established for ACHs and subject matter experts. The forum will facilitate collaboration on shared approaches, tools, resources, planning, and deployment across ACHs.

We are currently utilizing tools and guidance provided by workforce subject matter experts and HCA consultant, Manatt, in our regional project and implementation planning. We intend to continue to utilize the tools and look forward to additional tools and guidance emanating from the statewide workforce forum. Our workgroups, Strategic Improvement Team, and Quality & Continuous Improvement Committee will use statewide templates and resources in our regional needs assessment and planning efforts. Healthcare services and supports will be accessible to people from all backgrounds, ethnicities, and cultures (PCACH has developed a Communications Plan and Channel Matrix that will support transparency and information flow. (See Attachment 202) Services and supports will be located within the communities served, and providers should be representative of the diversity of the community as a whole. Furthermore, patients should have a level of understanding and confidence sufficient to ensure self-management and activation in their own care and treatment. Thus, PCACH's workforce initiatives will:

- Encourage partnering providers to adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as well as the Institute for Health Improvement (IHI) Health Equity Call to Action;
- Support care coordinating agencies that employ community health workers (CHWs) who have

lived experience working in communities disproportionately impacted by poor health outcomes;

- Deepen cultural competency and humility, in the case of the opioid strategies, through harm reduction and trauma- informed care training, which reduces stigma and encourages trainees to see themselves in the people they serve;
- Promote shared decision making so patients and providers work together as active participants in care;
- Track and promote patient activation to ensure interventions that build patient skill and confidence in engaging in their care and treatment; and
- Encourage establishment of advanced healthcare directives to reduce involuntary and compulsory treatment.

PCACH will continue with the strong partnerships we have developed at state and federal levels. We have a strong partnership underway with the Washington State Department of Health in aligning expertise and resources from Practice Transformation HUB, Transforming Clinical Practice Initiative - Pediatrics (TCPI), Office of Rural Health, and critical Health Living Collaborative and CHW and Peer Support efforts.

PCACH will also pursue strategies intended to be responsive to equity and cultural competency of health workers.

PCACH will also learn from and align with Workforce Central and the recommendations outlined in the Skills Gap Analysis and Sector Strategies for Pierce County. PCACH is partnering with the Pierce County Workforce Development Council to access local workforce data, learn about and help develop local initiatives, and align with existing regional assessment efforts.

Population Health Management Systems

PCACH recognizes that effective population health management systems are a critical component of transformation across projects. PCACH has initiated a collaborative process to work with partners and stakeholders, consultants, and staff to design an approach to identify Population Health Management Systems (PHMS) needs and interoperable solutions. This approach will involve establishing PHMS across the region, using PHMS to support key activities, and supporting and maintaining PHMS to ensure sustainability.

PCACH's approach seeks to establish PHMS to support:

- Identifying, assessing, and educating partners on the technology solutions available to increase the interoperability of the PHMS;

- Increasing health information exchange (HIE) to provide better intelligence for partners across the region for whole-person care, integration, quality improvement, and value-based purchasing;

- Implementing care coordination systems to include both clinical and social elements of data to improve whole person health; and

- Telecom connectivity (increasing access to/infrastructure) in rural areas and telehealth solutions

PCACH will use PHMS across projects to support the following:

- Data collection for reporting;

- Data analysis for intelligence;

- Quality Improvement strategies;

- HIE to support integration and coordination;

- Driving and supporting value-based payments;

- Risk stratification for resource prioritization;

- High-risk patient identification and action;

- Care coordination;

- Exploring potential Chronic Disease Registries; and

- Telehealth.

PCACH's approach to supporting and maintaining PHMS across all projects will focus on:

- Assessment of critical needs and options;

- Vendor procurement, management, and coordination;

- Vendor accountability;

- Technical assistance for partners;

- Training for partners; and

- Financial support for partners.

PCACH's approach to PHMS encompasses strategies to successfully capture, collect, analyze and exchange data, while utilizing the most efficient, cost-effective, and wide-reaching technology available. In order to realize our vision and develop this approach, we have:

- Employed a chief information and technology officer (CITO), to be shared with SWACH.

- Contracted with Providence CORE for data, analytic and evaluation services.

We will:

- Convene an HIT/HIE workgroup comprising CIO/CTO-level participants from participating providers/partners. This group will be staffed by PCACH's CITO and will be charged with developing a regional HIT/HIE plan, prioritize initiatives, and make recommendations for investments in PHMS solutions.

- Establish an Infrastructure and Systems Capacity Building Fund to provide resources for technology planning, purchasing, training, technical assistance, and on-going maintenance and support for participating providers; and

- Adopt proven-technology systems that allow for new and innovative strategies to support transformation efforts.

This approach will ensure interoperable technology that supports the region's goals and transformation work will be identified, procured, and implemented to enable PCACH to successfully achieve outcome metrics.

Next steps for PHMS work:

- Phase II Partner Inventory / Field Assessment (January 2018)

- Convene HIT/HIE workgroup (January 2018)

- Compile Assessment Responses (February 2018)

- Assess Options (March 2018)

- Prioritize Recommendations (March 2018)

- Begin Developing Implementation Plan (April 2018)

PCACH encourages HCA to collaborate with the ACHs to develop standardized reporting tools for the MTP. Offering our partners, a standard data collection framework will enhance participation and lessen the burden on providers and ACHs. This will be especially helpful for those providers who cross ACH regions and do not want to have varied reporting requirements. It also offers HCA an opportunity to streamline the reporting process to CMS. PCACH looks forward to continuing to work with HCA on the statewide HIT/HIE Strategic Roadmap and to partner on strategic initiatives that will allow us to leverage capabilities in place today, as well as those that will emerge in the future.

Identification of Necessary PHMS with Partnering Providers

PCACH has begun to identify PHMS in the region through an initial, Phase I Partner Inventory of providers and CBOs to ascertain the predominant EHR and exchange technologies in use across Pierce County region.

Our large systems are Accountable Care Organizations (ACOs) and are utilizing EPIC as an EHR (MultiCare, CHI Franciscan), MultiCare is also using "PsychConsult" from Askesis in their behavioral health settings. CHI Franciscan uses Care Everywhere within EPIC to track and connect for Physical and Behavioral health). We will evaluate the infrastructure that both ACOs have built to see if it is appropriate to build upon their models to scale and spread regionally. Our two FQHCs (Sea Mar and Community Health Care) are using separate EHRs for physical and behavioral health (Allscripts, Cerner, Tele-Psych for Sea Mar and EPIC for CHC, respectively), the Independent Practice Association, Northwest Physicians Network (NPN); Pediatrics Northwest is utilizing EPIC is utilizing a variety of EHRs and Clarity. Other providers including our Behavioral Health providers are utilizing a myriad of EHR platforms, and varied versions of those platforms or not utilizing an IT system and we have connectivity issues with our rural community partners. These variations require technological solutions which will support interoperability and increased sharing of information to support our system transformation efforts. Additionally, most community-based organizations have no capacity to collect or share information electronically.

To date, we have identified the following health information sharing systems in use in the region:

- Care Anywhere (EPIC)

- Care Everywhere (EPIC)

- EDIE/Pre-manage (CMT)

- Clinical Data Repository (OHP)

- PsychConsult from Askesis

- Cerner

- Allscripts

- Direct Secure Messaging

- Clarity

We also know that there are also other systems that need to be evaluated for our region such as: Carequality, Reliance e-Health Collaborative, and Commonwell.

Next steps include a deeper assessment of partnering providers to ascertain more detailed information, including information on the use and satisfaction of the above-listed systems and providers' views on these systems' capabilities, capacity, and gaps. Under the direction of our CITO, PCACH will release our deeper assessment in January 2018 with a one-month response window, to allow for follow-up inquiry. Our CITO and the HIT/HIE workgroup will assess responses. Based upon evaluation of the assessment, PCACH may develop a Request for Information for more detail from the service providers of health information systems currently in use in the region, as well as for other options not currently in use in the region. PCACH intends to play a convener/coordinator role to find the best options for technology solutions and to work with our individual provider organizations to implement these solutions.

Work with Partnering Providers, MCOs and Other ACH Stakeholders

Successful interoperability and health information sharing requires the commitment of provider organizations expected to use the technology. PCACH is cognizant that success in this area will require a thoughtful and transparent stakeholder engagement process. PCACH intends to convene an HIT/HIE workgroup comprised of CIO/CTO leadership from partnering providers to review the assessment data and evaluate the potential opportunities for robust health information sharing to support implementation of the regional transformation strategies. This workgroup, reporting its findings to the PIP and RHIP Council, will ensure vigorous partner engagement to understand the benefits and implications of any technology decisions across our partnering provider spectrum. Selection of technologies to increase health information exchange will need to leverage prior investments, align the needs of the providers across the region, regardless of payer mix, and develop strong working agreements for how technology and information will be shared and used.

PCACH understands how vital health information exchange is to our success with the MTP, but also for the spread and sustainability of transformation across the health care delivery system spectrum. It is this core belief which underlies our decision to employ a shared Chief Information and Technology Officer (CITO) with PCACH and to allocate MTP and mid-adopter incentive dollars to the Systems Capacity Building Fund to allow PCACH to implement the technology approaches necessary to ensure MTP success, including laying the foundation for value-based contracting.

PCACH intends to use the Systems Capacity Building Fund to provide technical assistance, training, and coaching to partnering providers to ensure each organization can fully participate in decision-making regarding HIT/HIE investment and use, as well as successfully implement solutions. Additionally, PCACH recognizes the enormity of the requirements with which our clinical providers must comply: HEDIS, NCQA, MACRA, MIPS, MCO contract requirements, and each organization's individual goals and targets, to single out a few. PCACH is will support providers in adopting and using more advanced technology

solutions that do not increase administrative burdens.

Lastly, PCACH is mindful that technology is a fast-paced environment with changes in capabilities, functionality, regulation, and cost occurring daily. PCACH intends to bring a forward-looking perspective to the conversation on HIT/HIE, recognizing new technologies and regulations will continue to emerge throughout the coming years. PCACH wants to assist our region in understanding what is just around the corner and help it to make the most cost-effective and efficient decisions possible to avoid implementing strategies that will be obsolete before they are fully implemented.

PCACH is watching the emergence of Fast Healthcare Interoperability Resources (FHIR, pronounced "fire") standards describing data formats and elements and an Application Programming Interface (API) for exchanging clinical data contained in EHRs. One of FHIR's goals is to facilitate interoperability between legacy health care systems, to make it easier to provide health care information to health care providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems. The Office of the National Coordinator for Health IT (ONC) is piloting models for using FHIR and it is widely believed FHIR will become a required standard for all certified EHR products in the near-term future. Required implementation of FHIR would dramatically change the approach of the region to HIT/HIE. This technology would provide increased interoperability and potentially negate the need for health information exchanges or repositories. This could significantly change how providers use and exchange information and PCACH intends to be an education resource for providers on this front to help guide them in technology decision making.

Key project-related population health management systems relevant to both PCACH and the MCO include: care coordination systems as well as MCO claims-based population health analytics for improving provider panel management and quality performance monitoring and improvement. PCACH has hired both a CITO and a Director of Strategic Improvement to coordinate with MCO's and providers on necessary improvements / investments needed to these systems as well as ensuring coordination of these systems. The Director of Strategic Improvement will be accountable to aligning the projects with existing systems and developing best practices and workflows for those projects. For example, the HIT/HIE components related to Pathways (Community Based Care Coordination) will provide a software solution to support community- based care coordination and community-clinical linkages that address social determinants of health interventions. The data from this system will be used for providers, MCOs/payers and PCACH to see the progress and gaps in the care coordination strategy to adjust as necessary.

PCACH's next steps include a deeper assessment of partnering providers to ascertain more detailed information, including information on the use and satisfaction of the above-listed systems and providers' views on these systems' capabilities, capacity, and gaps. Under the direction of our CITO, PCACH will release our deeper assessment in January 2018 with a one-month response window, to allow for follow-up inquiry. Our CITO and the HIE/HIT Workgroup will assess responses. Based upon evaluation of the assessment, PCACH may develop a Request for Information for more detail from the service providers of health information systems currently in use in the region, as well as for other options not currently in use in the region. PCACH intends to play a convener/coordinator role to find the best options for technology solutions and to work with our individual provider organizations to implement these solutions.

It will also be the responsibility of the Director of Strategic Improvement and their team to coordinate with MCO's to leverage data from their existing systems for monitoring and quality improvement. It is important to note that most MCO's expressed a willingness to play a role in advising and interpreting claims- based data, but will not provide provider performance data to ACHs. This will present a challenge for the ACH in fulfilling its role in monitoring and providing quality improvement recommendations at a provider-specific level. Short of requiring providers to report proxy data out of their EHR's (an ask that is generally considered to be overly burdensome to providers), no solutions are available to ACH's to date. Because MCO's are required to share their data with a number of entities on a regular basis (including HCA, the Washington Health Alliance, and the Washington All Payer Claims Database), MCO's have communicated that these entities should be considered the primary entities for ACH's to engage with for data sharing needs.

In regard to existing processes and systems, PCACH engaged with MCO's to learn more about their existing efforts, process, and resources in order to develop and plan the role of the Strategic Improvement Teams to support providers as well as the Monitoring System. Below is an account of our lessons learned:

Supporting Providers in the Move to VBP and Clinical Practice Transformation

MCO's have a suite of differently qualifying VBP contracts that span the HCP-LAN spectrum of VBP and are designed to meet providers where they are at on that spectrum. This includes quality-based contracts that align with the Demonstration measures. The movement to VBP requires strategic support for providers to ensure success. MCO's as well as ACH's have a support role and a shared incentive to support their providers. The payment structure and the data are in place to drive providers toward outcomes – as ACH's work with providers to identify barriers to achieving these outcomes – this can be built into an ACH's TA/funding plan to "close the gap" for providers.

1) General Coordination of Technical Assistance

Because Providers contract with multiple payers and manage various kinds of payment models – it's important to keep in mind how overwhelming various assistance can be to providers. In some cases, all five MCO's could be trying to engage the exact same clinic. The ACH could potentially play a key role in coordinating and communicating TA support with MCO's. Minimally PCACH should avoid duplicating this support. ACH's are required to do monitoring on their performance measures and support providers in continuous quality improvement during the Demonstration. Working in coordination with MCO's who are already doing this work will be critical.

2) Performance Monitoring and Improvement Program

Some MCO's support for providers moving to VBP consists of a robust performance monitoring platform. In addition to providing reporting on key HEDIS and VBC metrics, these platforms also help providers identify gaps in care to improve PCP- paneled member engagement. There are often teams at the MCO that help the providers meeting those quality metrics.

Making data available is key – but using this data to inform clinical practice or change how a patient's care is managed takes time, and for providers this is often unpaid time. ACH's could work with providers to understand how to overcome barriers so that there is a more robust use or take-up of these resources. A next step could be to learn more about these MCO programs and how the metrics are calculated to integrate it into ACH support for improving outcomes (self-monitoring) on pay for

performance Demonstration measures.

3) Population Health Management Analytics and Processes

When doing continuous quality improvement and examining key ACH measures like Emergency Department utilization and measures associated with ideal patterns of preventive care, PCACH will work with the MCO's and providers to understand the makeup of the MCO population/provider panel. It is critical to look at data by demographic and other characteristics that are associated with patterns of use of care. MCO's recommend that when looking at PCACH's Medicaid population and performance measures, that the data be explored by rate category/eligibility group (expansion, TANF, etc.) and demographic categories (male, female, language, geography, etc.). For example, there are differences at depression medication management by Spanish- speaking populations and non-Spanish- speaking populations. It is also important to use caution in interpreting results for smaller demographic/eligibility segments of the population.

A related topic to performance monitoring, is understanding the process of empanelment. Most MCO's have a process and algorithms in place to do assignment of members to PCPs. First, members can choose a PCP, but if they do not they are then auto-assigned (within one day of receiving eligibility file from the State) based on PCP proximity to member address and member age, gender, language-related preferences/needs. Health Homes assignment may also a part of this process for those who meet those eligibility criteria.

Prioritize the advancement of statewide and regional innovations and approaches to HIT/HIE

The more robust the HIT/HIE technology, the more beneficial it will be to the work at hand. PCACH will prioritize those statewide and regional innovations and approaches to HIT/HIE that deliver the greatest value to our partnering providers and the region. The HIT/HIE workgroup will provide a forum to analyze assessment responses and filter the data to bring the decision-points to the table for decisions. As explained above, PCACH understands that the best technology solution is the one that brings the most value to the individual partners as well as the region.

PCACH intends to use the HIT/HIE workgroup to develop a two-dimensional prioritization methodology; first to prioritize by value and then by identity. Value will include determining a technology's ability to solve the most pervasive problems shared by the most partners. PCACH seeks to help providers use technology to drive innovations as well as solve problems, and we will continue to use the HIT/HIE workgroup to tease out new strategies for utilizing technology.

Continued involvement with the HCA HIT/HIE strategic roadmap efforts, stakeholder engagement opportunities, and a keen sense for what is just around the corner, will allow PCACH to provide technology solutions to support the MTP. PCACH intends to continue to partner and collaborate with other ACHs and will assist in the proliferation of technology solutions that can be shared across the state.

Areas of Improvement from Phase II Certification Application

Opportunity to emphasize PCACH's understanding of regional HIT needs and gaps.

PCACH believes we have answered these gaps from Phase II certification in our HIT/HIE section above.

Section II: Project-Level

2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation

Rational for Selection and Expected Outcomes

Bi-directional integration of physical and behavioral health is a central pillar in PCACH's overall theory of change, aligning with our first strategic aim (achieving whole person care using a quadruple aim framework) and our second (enhancing experience, quality, and value for health improvement). It also complements our region's status as a mid-adopter for full financial integration in 2019. To fulfill these aims, we will develop and support a clinically integrated system of care that meets people where they are and addresses their whole-person needs —physical and behavioral, with social needs included via our complementary *community care coordination* project—in a thoughtful and comprehensive way.

Evidence suggests that better integrated care provides a wide range of benefits for people and systems. It increases access to care, improves care outcomes, and helps reduce overall health care costs.[56] Since behavioral health disorders account for a significant number of preventable emergency room visits and hospitalizations,[57] it can also help optimize patterns of utilization and reduce the strain on systems and providers. Moreover, behavioral health disorders have been correlated with a median reduction of 10.1 years of life, largely due to untreated and ineffectively managed chronic health conditions which can be much more effectively managed in an integrated system.[58]

Regional data from our Regional Health Needs Inventory (RHNI) underscored the importance of choosing integration as a project area. A key stakeholder survey found that persons with co-occurring physical/behavioral health conditions were seen as the most important priority population for ACH project work. The need is high—nearly a third (28.4 percent) of adult Medicaid enrollees in Pierce have mental health diagnoses, but they are less likely to receive treatment than enrollees in other ACHs.[59] With 17,755 Medicaid enrollees with a dual diagnosis of mental illness and substance use, Pierce County's rate is higher than the state average (8.3 percent vs. 7.7 percent).[60] This challenge is exacerbated by the fact that Pierce County has been designated as primary care health professional shortage area. As a result, data suggest that 28 percent of acute non-pregnancy hospitalizations include a mental or behavioral health diagnoses, a rate much higher than the statewide average of 18 percent.[61]

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[56] Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs. 2008 May/June;27(3):759-769.

[57] Preventable Emergency Department Visits. Content last reviewed July 2016. Agency for Healthcare Research and Quality, Rockville, MD. Accessed: November 2017 Available: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

[58] Walker ER, McGee RE, Druss BG. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry. 2015 Apr;72(4):334-41.

[59] HCA Data Product: ACH Toolkit Historical Data

[60] DSHS ACH Profiles: https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

[61] HCA hospitalizations_ach_rhni_tables: https://wahca.app.box.com/s/mxpg8euzbjpdkmyuftzb4ri5v41ia8v9/folder/23928005433

Regional data about chronic conditions also underscored the need for better integrated care in the region. Approximately 27 percent of Medicaid enrollees in PCACH have been diagnosed with at least one chronic condition and nearly 22% of enrollees have co-occurring chronic conditions and behavioral health diagnoses.[62] Pierce also has high rates of potentially preventable hospitalizations; from 2013-2015, legislative districts comprising Tacoma, Lakewood, and Spanaway had the highest rates of preventable hospitalizations in the state. This may be another indicator of primary care access issues, since it suggests that some of those facing complex health challenges may lack access to the preventive care they need to manage their conditions effectively.[63, 64]

This project will support sustainable health system transformation by developing a clinically integrated system better equipped to diagnose, treat and manage complex, multi-dimensional health challenges within a single setting where the patient feels comfortable, whether it is a primary care or behavioral health clinic. There are at least three ways our integration initiative will help sustain health systems transformation:

1) **Optimizing Utilization & Reducing Systems Strain.** Integrated care creates optimized experiences for both patients and systems. Patients can get more of their total needs met at the same location, sometimes even in the same visit; this makes access to care easier and reduces the need for frustrating referrals and their associated wait times. From the systems perspective, more centralized care with fewer referrals reduces the overall complexity of sharing information across settings and managing appointments and schedules, potentially helping alleviate provider shortages in key areas.

2) **Reducing Unnecessary ED & Preventable Hospital Use.** Because the ED is a "one stop shop" with quick and guaranteed access, patients with complex health challenges may go to the ED to get needs met that could be handled elsewhere. Creating easy access to comprehensive care for complex populations in more appropriate settings may reduce these unnecessary visits and ease their burden on the system, while also reducing the total costs of care. At the same time, better management of complex conditions may result in fewer acute exacerbations of those conditions that might lead to otherwise avoidable hospitalizations.

3) **Improving Health & Management of Health.** People with complex health challenges are disproportionately likely to become high cost, high-utilizer patients when those health conditions cycle to a point of crisis. An integrated system will be better able to support patients in managing their own health and achieving their own health goals; healthier patients will mean fewer such crises, reducing the overall burden of complex health on the system and community.

Coordinated and Not Duplicative

To ensure coordination and avoid duplication, PCACH convened the Provider Integration Panel (PIP), a

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[62] HCA BH and Chronic Conditions data

[63] Healthier Washington Dashboard

[64] Office of Financial Management; Potentially Preventable Hospitalizations by Legislative District, July 2017

multi-disciplinary workgroup of community providers charged with connecting and aligning our ACH program work with existing and complementary initiatives in their own systems. The PIP conducted a partner inventory process with key stakeholders to learn about providers' experiences around integration and discuss coordinated solutions to move forward; results of that inventory informed the development of the PCACH "Transformation Rules of Engagement" for the Bi-directional Integration of Care project. These rules define a set of shared community approaches to integration that all stakeholders have agreed to infuse into their integration efforts, ensuring alignment of efforts across all partners.

During the Transformation Action Plan development period, PCACH will continue to convene workgroups of subject matter experts based on transformation of care and service delivery settings. Working through and with the support of the PIP, RHIP Council, Community Voice Council (CVC), and Data and Learning Teams (DLTs) within our governing structure, these workgroups will monitor our work, assess it against other existing efforts, and ensure that PCACH's work complements and enhances those initiatives rather than duplicating them. These monitoring workgroups will be convened in January 2018 and will meet regularly based on the goals established by and for each workgroup.

Anticipated Scope

Our approach to integration is predicated on a simple idea: by the end of the demonstration, all our partnering providers will have implemented the Collaborative Care Model (CoCM), with some elements of the Bree recommendations where flexibilities are necessary for the partnering provider. The CoCM has demonstrated success in delivering integrated healthcare to patients in the care settings that are most familiar and comfortable to them, whether that is the primary care clinic, the behavioral health center, or someplace else. CoCM allows leveraging of limited financial and human resources; we think it will also increase the capacity for improvement and innovation across agencies and care settings.

Anticipated Target Population

Our intent is to build a clinically integrated system of care that benefits everyone, so our eventual target population includes all 230,000 Medicaid enrollees in the region. However, for the purposes of the Demonstration project, we are especially interested in impacting outcomes for a more refined target population that includes Medicaid members with a diagnosed behavioral health disorder (approximately 82,000 individuals, about half of whom also have a co-morbid chronic health condition). These "complex health" members represent those mostly likely to benefit immediately from integration, because their health needs include services that would be delivered across systems that are more fragmented than they will be once our work is done.

Because bi-directional integration project 2A focuses on system transformation rather than a program or intervention, the selected target population is purposefully broad. PCACH will be working closely with primary care, pediatric, and behavioral health providers to integrate and improve care, with the intent that these changes will apply to all patients that interact with a provider.

The process for selecting target populations engaged stakeholders to review available data and consider the following criteria and key questions:

Criteria	Key questions
Need	• Does the priority population disproportionately experience poor health outcomes? • Are there subgroups within the population that experience disparities? • Is there a gap in existing services to effectively address these outcomes?
Impact	• Is there strong potential for the project/intervention to improve outcomes for the priority population in 2-3 years? • Is the priority population large enough for improvements to drive community-wide outcomes?
Data Feasibility	• What data currently exist to explore the priority population, track outcomes, and evaluate impact?

Please see information below for more information on the expected impact of the project outlined below that was provided in our original project plan submission:

We anticipate that, as a result of this project, individuals in the region will have better access to the care they need, less hassle and an improved patient experience, and better quality of care as they engage with a system that is prepared to coherently address the complex and interrelated drivers of their health challenges. As a result, our region will see improved health outcomes as better diagnosis, treatment, and management of behavioral health disorders and other co-morbid chronic health conditions becomes second nature to our partners. As access improves and health outcomes get better, we will see more appropriate utilization of services such as Emergency Department visits, fewer potentially avoidable hospitalizations, and lower per capita costs for the region. We anticipate these outcomes will eventually spread across the region to everyone's benefit but will initially be more pronounced in our PCACH Narrative Section II Write Back 1 20171218 5

targeted subpopulations because they currently face the greatest challenges in navigating a fragmented system of care.

The target population for Bi-Directional Integration will include all Medicaid beneficiaries, both children and adults. Since Project 2A focuses on clinical transformation, we aim impact care for all the roughly 230,000 Medicaid enrollees in the region. About 105,000 (46%) Medicaid enrollees in Pierce County are under age 19. Pediatric providers will, therefore, be key partners in this work.

For the purposes of the Demonstration project, we are especially interested in impacting outcomes for a more refined target population that includes Medicaid members with a diagnosed behavioral health disorder. Through June of 2016, approximately 59,000 individuals had a behavioral health diagnosis. Of

these members, more than 17,000 (29%) are under age 19 and about 70% also have at least one co-morbid chronic health condition. These "complex health" members represent those mostly likely to benefit immediately from integration, because their health needs include services that would be delivered across systems that are more fragmented than they will be once our work is done.

The target population for Bi-Directional Integration will include all Medicaid beneficiaries, both children and adults. Pediatric partners will focus primarily on Medicaid enrollees under age 19. Since Project 2A involves clinical transformation, we expect all members to be impacted by this project. A key subpopulation of interest for Project 2A will be Medicaid enrollees with behavioral health diagnoses. The table below shows the count of members with behavioral health diagnoses through June 2016, by age group.

Age Group All Members Mental Health or Substance Use Disorder Diagnosis

Age Group	All Members	Mental Health or Substance Use Disorder Diagnosis
All	190,993	58,972
0-11	62,221	7,980
12-19	31,543	9,151
20-29	31,007	11,654
30-39	26,989	12,264
40-49	16,908	8,039
50-59	16,147	7,615
60-69	6,125	2,616
70-79	35	--
80+	18	--

It's also worth noting that detailed age breakouts are not available for all data sources. Enrollment data currently report the number of adults and children receiving Medicaid in a region. As more detailed data become available, PCACH will use that information to refine their target population for this project.

Beginning in Q1 2018, PCACH's PIP and Strategic Improvement Team (SI Team) will work to further refine this target population, narrowing our focus to specific complex health subpopulations where the greatest opportunities for improved outcomes and cost savings may lie. For example, we may narrow our focus to complex health individuals with two or more recent emergency department visits, or on complex health individuals who live in areas of PCACH where data show unusually high rates of potentially preventable hospitalizations.[65] We intend to work closely with our data partners and the Data Learning Team to analyze existing data and build a strong empirical basis for our narrower initial targeting.

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[65] Office of Financial Management; Potentially Preventable Hospitalizations by Legislative District, July 2017

Partnering Providers Thus Far

Primary care and behavioral health providers will be key partners in implementing bi-directional integration, but the problem is larger than that, and health providers can't do it alone. Other community partners also play key roles in integration, such as providing culturally appropriate care or wrap around supports for patients who also suffer from complex social needs. To do integration right, we need to partner across sectors and address our priority population's needs with a comprehensive, community-based approach to integration. To that end, we will work with clinical and behavioral health providers, hospitals and health systems, governmental agencies and offices, Tribal government providers, public health, emergency services, and community-based organizations to obtain an on-the-ground understanding of the priorities, capacity, resources needed to make integration work in our region.

Thirty-eight (38) partnering providers have already submitted letters of interest (LOIs) indicating a commitment to work with PCACH in the planning and implementation phase of our integration project:

Table 8. Partnering Providers who have submitted LOIs to PCACH

• Catholic Community Services	• Lutheran Community Services Northwest
• Center for Dialog & Resolution	• Metropolitan Development Council
• Central Pierce Fire & Rescue	• MultiCare
• CHI Franciscan Health	• Northwest Integrated Health
• Children's Home Society	• Northwest Physicians Network
• City of Tacoma Fire Department	• Orting Valley Fire & Rescue
• Community Health Care	• Pediatrics Northwest
• Comprehensive Life Resources	• Perinatal Collaborative of Pierce County
• Consejo Counseling & Referral Services	• Pierce County Office of the County Executive
• Crisis Clinic	• Pioneer Human Services
• East Pierce Fire & Rescue	• Planned Parenthood GNHI
• Emergency Food Network	• Point Defiance Aids Project/ NASEN
• First5Fundamentals	• Prosperity Wellness Center
• Gig Harbor Fire & Medic One	• Samoan Nurses Organization (SNOW)
• Graham Fire & Rescue	• Sea Mar Community Health Centers
• Greater Lakes Mental HealthCare	• Sound Outreach
• Hope Sparks	• Tacoma-Pierce County Health Department
• Korean Women's Association	• United Way of Pierce County
• Leaders in Women's Health	• West Pierce Fire & Rescue

Consideration on Level of Impact

We anticipate that, as a result of this project, individuals in the region will have better access to the care they need, less hassle and an improved patient experience, and better quality of care as they engage with a system that is prepared to coherently address the complex and interrelated drivers of their health challenges. As a result, our region will see improved health outcomes as better diagnosis, treatment, and management of behavioral health disorders and other co-morbid chronic health conditions becomes second nature to our partners. As access improves and health outcomes get better, we will see more appropriate utilization of services such as ED visits, fewer potentially avoidable hospitalizations, and lower per capita costs for the region. We anticipate these outcomes will eventually

spread across the region to everyone's benefit, but will initially be more pronounced in our targeted subpopulations because they currently face the greatest challenges in navigating a fragmented system of care.

Health Equity

Health equity has been a foundational element in all matters of project design for PCACH, and integration is particularly important because it addresses the needs of populations who have been historically marginalized or stigmatized in a fragmented health system. To ensure our integration work keeps equity at its core, we will:

1) Use Data to Track Disparities: Our data infrastructure will be designed to explicitly track progress against our integration process and outcome measures in terms of disparities. We will make that data transparent and available to all of our partners.

2) Connecting across Projects to address Social Determinants of Health: Our *Bi-Directional Integration* project intersects with our *Community Care Coordination* project to present a comprehensive, whole-person approach to integration that stresses the importance of social determinants of health that are the fundamental underpinnings of health inequities. By addressing those underpinnings, we will move toward improved equity across our region.

3) Provider Trainings: We will move beyond training providers and partners on the *mechanics* of integration and provide focused supports around the key issues of stigma, power, and inequity as they relate to whole-person care. We will ensure that trainings are available in multiple languages and across diverse cultural and geographical community sites.

4) Cultural humility and Trauma-Informed Care: These will be incorporated as essential components of the Strategic Improvement Team's work as it embeds itself within our practice sites and community partners to support integration efforts.

5) Equity Lens on Policies & Systems: An equity lens will be critically applied to all policies, procedures, and systems within PCACH, and we will work to extend that lens to our partnering provider organizations as well.

Lasting Impacts and Overall Benefit

PCACH isn't just about funding projects; our mission is to start with programs that focus on priority populations where we can have immediate impact, then leverage those successes to build out and support a model of change that helps our region continue to do collective work that creates a healthier community. Our approach to bi-directional integration is a perfect example of this: providers will build systems for integrated care in our priority population, but will soon see the benefit of deploying and supporting those same systems for other populations. We see promise in an approach that starts with a focused target population within Medicaid, then spreads to the Medicaid program as a whole, and then to Medicare and the commercial market. We expect that our deep collaboration with providers, CBOs and other stakeholders will ultimately lead to a broad transformation that simply sets a new standard for how health care is done in our region – a standard where whole-person integrated care for all those who seek it.

Partnering Providers

Serve a Significant Portion of Medicaid

How PCACH has included partnering providers that collectively serve a significant portion of the Medicaid population: Partnering providers have been heavily engaged in project development through community meetings, participation in discussions and decision-making in ACH workgroups and councils, and through direct outreach from ACH leadership. To further assess interest and capacity, a partnering provider inventory was disseminated to our partners in DY1, Q4. The provider partners who completed our inventory collectively served at least 170,000 Medicaid lives in primary care settings and 29,000 in behavioral health settings in 2016, while community-based organizations, fire and rescue, and other support services provided services to more than 50,000 Medicaid enrollees in 2016. Because this partner inventory was inclusive of almost all key Medicaid serving entities in the region, we estimate that their participation in this project means we can reach at least 90 percent of the Medicaid population being served in Pierce County with this program.

We recognize that there is a gap to address here: more will need to be done to identify and outreach to those Medicaid members who could not be included in the partner totals because they are not accessing care.   We intend to work closely with community-based agencies and organizations who may be providing other kinds of services to those members to ensure that their needs are met within our emerging, more integrated system of care.

Ensuring Partnering Providers Commit to Serving the Medicaid Population: Our approach to ensuring Medicaid members are served by our partners is contractual: by Spring 2018, PCACH will secure contracts with partnering providers that include a formalized commitment to our region's approved "Transformation Rules of Engagement," which outline the essential activities all partners agree to undertake as part of each of our community transformation programs, including a commitment to serving the target Medicaid population in the region. To verify compliance, our plan for ongoing Monitoring and Continuous improvement will also provide tools for reporting and systems for auditing how many Medicaid clients our partners are serving, along with strategies to help partners achieve desired targets in our priority populations.

Process for engaging partnering providers and ensuring that a broad spectrum of care and related social services is represented: As previously mentioned, in early 2017 PCACH established a PIP that will continue to engage a broad spectrum of partnering providers in the identification of regional needs and development of the bi-directional integration project. In 2018, our deep partnerships with providers, health systems, community-based organizations and other stakeholders will remain a focus throughout the planning period. PCACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with city, regional, state and local officials.

Leveraging MCO's expertise and Aligning with their Efforts: PCACH has been working closely with MCOs to leverage their expertise, identify areas of alignment, and ensure there is no duplication of services or programs. MCOs have been active participants across all PCACH councils and workgroups, through these roles, MCOs have directly informed discussions and decisions pertaining to project selection, target populations, and PCACH's Transformation Rules of Engagement. We anticipate that additional partnership will happen in our upcoming launch of the value-based payment (VBP), health information exchange (HIE)/health information technology (HIT), Workforce and Quality and Continuous workgroups.

In addition to this intentional and broad engagement, PCACH has met with each MCO over the past several months to explicitly explore the following key questions:

1) What is the makeup of your member population?
2) What key population health strategies are already underway?
3) How can PCACH complement existing MCO efforts in the area of provider support?
4) What opportunities for alignment exist with regards to measures, key metrics, and quality improvement efforts?
5) How can PCACH support the rollout of provider VBP contracts?
6) How are primary care providers (PCP) assignments and empanelment determined?
7) What is needed to ensure the sustainability of demonstration projects?

As a result of these conversations, PCACH and MCOs have mutually identified the following opportunities for deepened and coordinated work that can support our integration project goals:

1) Assessment and support to expand provider readiness for VBP contracts,
2) Optimization of data sharing to inform monitoring and continuous quality improvement,
3) Provider support regarding utilization of data to inform quality improvement efforts,
4) Provider support regarding adoption of effective strategies to improve patient engagement, and
5) Coordination between the Pathways Community HUB and Health Home models to ensure that members needs are being met, duplication is avoided, and value-based payment methodologies are advanced.

Through ongoing coordination and participation on PCACH councils and workgroups, MCOs will actively inform the final planning, implementation and sustainability phases for all demonstration projects, including the Bi-Directional Integration project.

Commitment to Serving Medicaid

Our approach to ensuring Medicaid members are served by our partners is contractual: by Spring 2018, PCACH will secure contracts with partnering providers that include a formalized commitment to our region's approved "Transformation Rules of Engagement," which outline the essential activities all partners agree to undertake as part of each of our community transformation programs, including a commitment to serving the target Medicaid population in the region. To verify compliance, our plan for ongoing Monitoring and Continuous improvement will also provide tools for reporting and systems for auditing how many Medicaid clients our partners are serving, along with strategies to help partners achieve desired targets in our priority populations.

Process for Engagement

As previously mentioned, in early 2017 PCACH established a PIP that will continue to engage a broad spectrum of partnering providers in the identification of regional needs and development of the bi-directional integration project. In 2018, our deep partnerships with providers, health systems, community-based organizations and other stakeholders will remain a focus throughout the planning period. PCACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with city, regional, state and local officials.

Regional Assets

The most important asset that PCACH and the partnering providers bring to the bi-directional space is

the deep knowledge and experience providing varying degrees of integrated care in the region. Many of our providers have established models of integrated care, and some have developed accountable care organizations that will augment the regional transformation efforts. In many cases these efforts have not been scaled across the community due to underlying health system transformation challenges, including workforce, HIT/HIE and financial sustainability, but PCACH is well positioned to address those barriers and leverage the development of this project application to help spread these practices and build a coherent regional approach to integration.

Anticipated Challenges or Barriers

We face significant challenges in improving outcomes and reducing costs through our integration program – if it were easy, someone would have done it a long time ago. Key barriers include:

1) Information Exchange: The lack of a coordinated information exchange has created a challenge for providers to access patient care data to support integration. In some cases, the regulatory environment makes sharing information about a person's "whole health" difficult, even for health care providers.

2) Lack of Analytic Infrastructure: Integration is most likely to produce immediate impacts for high-risk populations, but there is no regional analytic infrastructure for identifying and targeting those patients or creating unified care plans.

3) Key Workforce and Community Service Shortages: Significant workforce shortages exist in both behavioral health and primary care in our region, and there is a dearth of important community services to support some of the social determinants of health.

4) Need for Training: Partnering providers will need new and ongoing training in the collaborative care model and trauma-informed practice in order to support systemwide transformation and ongoing success.

Mitigating Risks and Barriers

We have several strategies in place to mitigate these risks and overcome identified barriers:

1) **HIT/HIE Investments:** PCACH's approach to HIT/HIE encompasses strategies to successfully capture, collect, analyze and exchange data, while utilizing technology that is efficient, cost-effective, wide-reaching, and interoperable. To realize our vision and develop this approach, we have employed a chief information and technology officer (CITO) and contracted with Providence Health & Services' Center for Outcomes Research and Education (CORE) to provide data services in support of our transformation vision. Next steps will include:

   - Convening an HIT/HIE workgroup comprising chief information officer (CIO)/chief technology officer (CTO) level participants from participating providers/partners. This group will be staffed by PCACH's CITO and will be charged with developing a regional HIT/HIE plan, prioritizing initiatives, and making recommendations for investments in PHMS solutions

   - Establishing an Infrastructure and Systems Capacity Building Fund to provide resources for technology planning, purchasing, training, technical assistance, and ongoing maintenance and support for participating providers. We will adopt proven-technology

systems that allow for new and innovative strategies to support transformation efforts.

- Partnership with experienced analytic partners to design and aggregate data in ways that allow for identification of priority populations.

2) **Workforce Investments:** PCACH will leverage the efforts of the *Workforce Development Council* to provide a high-level assessment of workforce capacity and gaps in Pierce County and develop a targeted approach to workforce needs for bi-directional care. Solutions being considered in this area include:

- Using telehealth and telepsychology as potential solutions to workforce gaps in urban and rural areas of the region.

- Working with the Puyallup Tribe to assist, encourage, and incentivize members of their clinical residency program to be retained within the region's workforce.

- Exploring solutions to recently identified licensure barriers for the state's behavioral health residential treatment programs.

3) **Transformation Rules of Engagement**: Beginning in mid-2017, the PIP began developing White Papers on bi-directional integration, chronic care, and primary care medical homes. These *Transformation Rules of Engagement* (see attachment 1) define the expectations for partners throughout the region that are participating in bi-directional integration, outlining design, practice change, tools and validated screening instruments, performance management, equity and inclusion, reporting expectations, and other requirements for participating in transformation efforts sponsored as part of the MTP. The goal of developing the Transformation Rules of Engagement early was to gain consensus, establish the expectations, and develop a reginal model while enabling the providers and partnering organizations the opportunity to plan for practice and organizational change and upcoming delivery system change.

4) **The Strategic Improvement (SI) Team**: The SI Team is complementary in nature to the PIP and will be responsible for supporting the success of the Bi-Directional Integration project by providing trainings and support to engaged providers to ensure their successful implementation of the project. The SI Team will do this by arranging trainings, establishing learning collaboratives and other opportunities for shared learning across the project's partnering providers. Trainings will encompass what it means to provide integrated care and will evolve to meet the specific needs of the Medicaid population.

Monitoring Implementation Progress

PCACH is building a project monitoring and continuous improvement data and reporting infrastructure to support the Demonstration project portfolio and achieve our targeted goals across all project areas. Our project monitoring and continuous improvement system relies on several core components: strong infrastructure of timely data, continuous data monitoring and analysis, and reporting at multiple levels including providers, community, PCACH governance, and state levels.

Figure 21. Process for Monitoring and Continuous Improvement
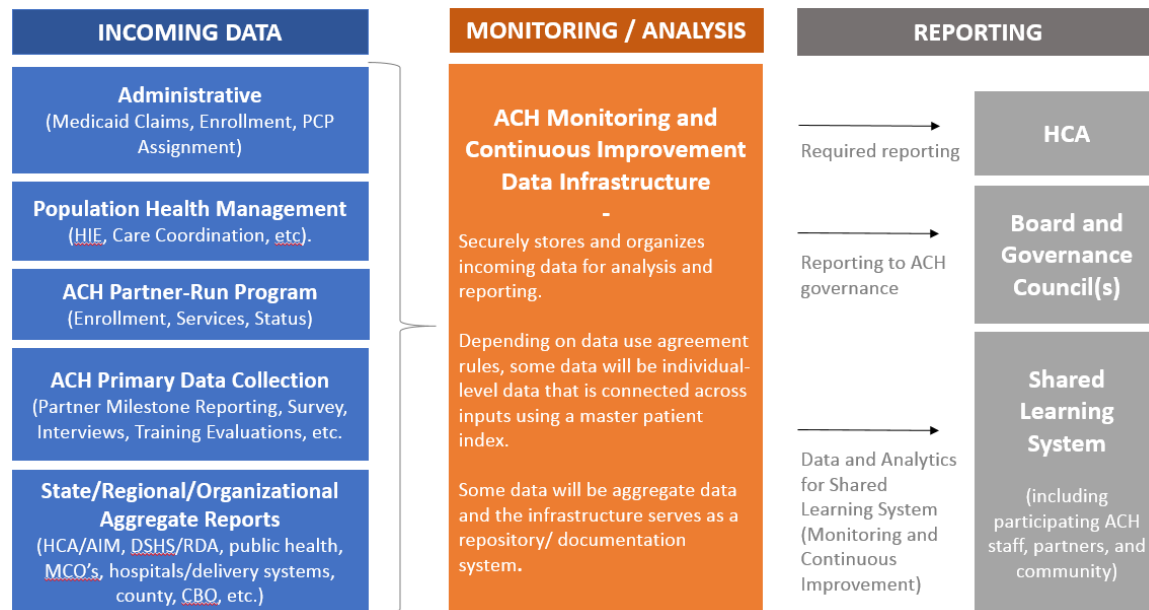
The data infrastructure to support monitoring and continuous improvement will be designed to complement existing data assets (such as the ACH Data Dashboards provided by HCA) and will build upon "point of care" population health management system inputs needed for projects. Identified data sources include those associated with pay for reporting (P4R) and pay for performance (P4P) metrics, as well as key data needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

Data Partnerships: PCACH has contracted with the Center for Outcomes Research & Education (CORE) at Providence Health & Services to design and run the monitoring system. CORE has a long history of designing and operating similar systems in support of accountable care and population health efforts. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a single, centralized hub for implementation monitoring, quality improvement, and evaluation activities.

Use of Data to Adjust for Delays: Implementation progress and the status of timelines will be monitored by the ACH with clear lines of communication and accountability between partnering providers, PCACH staff, CORE, and our PCACH governance body. Adjustments to implementation timelines will be triaged through our data and monitoring system, and course corrected wherever possible. If timelines still cannot be met, the PCACH will communicate a plan back to the state regarding reasons why timelines weren't met, a plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Monitoring Continuous Improvement

PCACH will use the data generated by our monitoring system to create and run a rapid cycle feedback and quality improvement process that bridges all the organizational partners to ensure successful progress toward milestones and outcomes. This system will incorporate a comprehensive shared learning system that follows the best practice of a "Plan, Do, Study, Act" (PDSA) continuous quality

improvement process, with data at its core.   The system will be informed by key planning inputs that better position PCACH to invest in and provide key supports to providers and organizations, ensuring they meet the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and PCACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the Demonstration for each project area.

PCACH has developed a Strategic Improvement infrastructure that consists of Improvement Advisors that provide support for providers – across all projects – to achieve continuous improvement. The following content on the key general supports will apply across the board for projects, but project-specific supports like the exact trainings, tools, and technical assistance will vary by project and provider and will unfold as these teams undergo a process for developing specifics. The following content outlines the general supports and approach, the process for developing specifics (including some example specifics), and additional thinking and work done to date related to this topic.

Key general supports for partnering providers to achieve continuous improvement include:

1) PCACH-funded Data Analytics, Performance Monitoring, and Quality Improvement Processes and Programming, including the following examples of key general supports:

- Strategic advisement and technical assistance on defining project metrics
- Strategic advisement and technical assistance on data collection best practice and methods for tracking metrics and ensuring provider proficiency at reporting on required PCACH and MTP level reporting requirements (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and regularly report on a monthly, quarterly and annual basis
- Strategic advisement on how quality and other metrics are measured and related technical assistance to improve reporting and documentation process
- Strategic advisement on how to improve quality outcomes and tools for achieving those outcomes
- PCACH-wide performance monitoring dashboards
- Where possible, data analysis of performance to understand what's driving performance rates and forecasting related to hitting targets
- Ensuring participating providers and partners have pay for reporting tools and capabilities in place
- Assessments on connectivity with various partners data including administrative data, MCOs, CCS (Pathways) platform and Chronic Disease, etc. for data and pull together (with CORE's oversight) for regional dashboard
- Ensuring shared learning system is accelerating implementation, spread, and scale-up of innovative approaches to improving health outcomes
- In addition to the Data Analytics, performance Monitoring, and Quality and Continuous Improvement, PCACH is funding Strategic Improvement Team consisting of Improvement Advisors and Continuous Quality Improvement workgroup. These resources will leverage the data provided to guide their efforts in providing technical assistance, practice coaching, and trainings to the providers.

Identification for Initiatives or Strategies Not Working

The comprehensive shared learning system and PDSA continuous improvement process will support PCACH and our partners to rapidly identify opportunities for course correction and adjust strategies to meet our outcomes.

PCACH-funded Strategic Improvement Team (SI Team) and Quality & Continuous Improvement Workgroup (QCI) will provide support for rapid-cycle feedback and quality improvement (Improvement Framework and Science of Improvement model. See Attachment 206 and 110). The following are examples of key general supports:

- The Strategic Improvement Team will work together with our provider practices and partners to ensure that all improvement efforts include, IHI's Science of Improvement steps:
  - A clear, measurable aim (focused on MTP projects are at the center - i.e. integration, opioid, chronic disease, transitional care, diversions)
  - A measurement framework in support of reaching the aim
  - A clear description of the ideas (content) and how these ideas are expected to impact the results (the causal pathway from changes to desired outcomes)
  - A clear description of the execution strategy (what will be done to ensure reliable adoption of the content?)
  - Dedication to rapid testing (PDSA cycles), prediction, and learning from tests
  - Understanding, describing, and visualizing systems (e.g., using a process map or value stream map)
  - Learning from variation and heterogeneity: Use of time-ordered data to detect special cause and improvement Understanding why results differ by location (ward, organization, etc.)
  - Application of behavioral and social sciences
  - Application of pay for reporting tools for improvement and waiver project reporting to enable payment and progress toward improvement
  - Building science-based improvement capability at provider, team, clinic-wide and system level Ensuring quality improvement knowledge and skills are provided to participating providers and health care workforce
  - Ensuring the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
  - Providing a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results
- The Quality & Continuous Improvement Workgroup will be an external team made up of quality and clinical improvement individuals in regional partnering organizations that support the quality improvement activities associated with PCACH's transformation efforts.
  - QCI Workgroup comprised of Quality and Clinical Improvement level participants from participating providers/partners, staffed by Director of Strategic Improvement;
  - Establishment the Systems and Capacity Building Fund to provide resources for quality improvement education, training, technical assistance, education, practice improvement and support for participating providers; and
  - Adoption of Science of Improvement methodology that allow for new and innovative strategies.

Project-Specific Supports: The above content describes the general approach to supporting providers for

continuous improvement. Due to the timing of writing this project plan and PCACH progress on hiring and staffing these key roles to facilitate deeper development of specifics, PCACH has not had staff in place long enough to articulate all of the project-specific measures, trainings, tools, etc. that they will provide, though PCACH was proactive at assessing each provider's specific needs, there has not been time to develop a resulting tailored QA plan.

That being said, PCACH can articulate the process by which they will develop more specific supports.

This process includes:

- Phase I Partner Inventory (COMPLETE) - PCACH has completed and reviewed a starting inventory of partnering provider interests, needs, and goals as it relates to the Demonstration project areas. This Phase I Partner Inventory was a 12-page document, exploring individual organization's interest and barriers to participation in MTP. The inventory was sent out in September 2017 to more than 70 distinct types of organizations, such as clinical providers, hospital systems, behavioral health providers, EMS, and community-based organizations. PCACH received over 30 responses, with approximately 10 from clinical providers and hospital systems, 10 from behavioral health providers and 10 from community-based organizations. This information has provided a starting point for the SIT to plan specific TA, training and education.
- Phase I Partner / Provider Guided Discussions for Portfolio Development (COMPLETE) – PCACH followed up with key providers to have more in-depth discussion based on inventory responses.
- Develop and Adopt Rules of Engagement (COMPLETE) - PCACH has developed and adopted Rules of Engagement that outline expectations of providers under the Demonstration. These rules will provide clarity on specifics so that the SI Team can develop a corresponding plan for support and identifying risks.
- Phase II Partner Inventory/Assessment (Upcoming) – PCACH will conduct a formal "current state assessment" across all projects that will provide an up-to-date inventory of current state and barriers/haps to achieving future state expectations (rules of engagement) and additional conversations for the implementation design phase.
- Implementation Design Phase (Under development and deployment upcoming) – PCACH will continue to engage providers during the implementation design phase. This engagement will involve developing out a plan for quality improvement and technical assistance (a strategic improvement toolkit) needed from providers to be successful in achieve milestones and outcomes by project.

Example 1:

- Partnering Provider A identifies in their inventory that they lack the technical systems needed to fulfill required reporting for a project area.
- PCACH has a follow up guided discussion with the partnering provider to understand why these systems are not in place – documenting the barriers and supports needed. This information goes into PCACH's planning process, of all provider barriers and supports that feed into PCACH's Strategic Improvement Team's
- PCACH developed out and governance structure and then the Board adopted the Rules of Engagement so that there are clear required expectations of that provider to fulfill the reporting while simultaneously co-developing with the provider- in planning and further development the implementation design phase, a plan for providing assistance to build up the providers capacity to fulfill reporting requirements. This could include strategic advisement and TA on tracking the

right inputs and extracting reports from their existing systems.

Real-Time Data / Day-to-day Performance

To date PCACH has explored options for data inputs for monitoring and quality improvement including proxy measures for performance monitoring and QI when ideal inputs may be unavailable. PCACH's goal is to identify data sources and/or processes that will help PCACH track provider/partner progress and/or activities that will lead to improvement for the pay for performance measures.

Problems – Access to Timely Data/Reports for Performance Monitoring and Analysis many of PCACH pay for performance measures will be subject to claims lag and other processes that will prevent PCACH from being able to monitor performance progress on these metrics in a timely manner. PCACH will also need access to data or reports on the metrics that will allow them to analyze the data to do things like identify disparities by population (are there specific populations that have lower rates of well child visits?), geography (are there differences in rural or urban communities on well child visits?), or provider (are there differences by clinic in well child visit rates?); and the interaction of these factors that could lead to identifying more complex issues.

Example: a key input for monitoring and QI could be Administrative Data on Medicaid Population through Medicaid Claims / Enrollment – the data source for the majority of the pay for performance metrics. Though this information is not real-time, it could be used for metrics forecasting. Providence CORE has a metrics and forecasting team that specializes in forecasting metric rates, though again, as PCACH's data analytics vendor, PCACH has been told that they cannot put agreements together to give their data analytics vendors access to these data for monitoring and QI.

Possible Solutions – Develop Proxy Measures and Data Sources: Despite barriers to access to data, PCACH will continue to work through the metrics and identify data sources and processes that could be explored as proxy sources (e.g. which health care settings are key to this metric? which project area implementation steps or program workflows and data that could have QIP metrics added to them?).

Examples:

1. ED Visits: Could a region reliably monitor ED visits through EDIE data as a proxy data source for the P4P ED measures? I mentioned the challenge of trying to translate EDIE data to a proper rate per member or rate per 1,000- member months would take some thinking. Since most of the performance measures have layers of criteria for inclusion and exclusion (especially those that rely on coverage or other utilization in claims) that a proxy data source may lack, there will be some instances where this will be more worthwhile/feasible than others. Continuing with this example, would we be able to explore EDIE data for patterns by population, geography, and/or emergency department? And for an ACH that might be interested in a monitoring approach that has a public surveillance lens to it – that ACH might leverage data like these to do more real-time community wide monitoring of emergency department use trends.
2. Clinical Processes: identify clinical processes that could be adapted and tracked to ensure that we see change within clinics that ought to lead to performance improvement. This falls perfectly into the world of QI.
3. Measures of Care Coordination: I mentioned that measures of care coordination will often have other systems where activities are tracked that could serve as process data. For example – in Oregon there was a program that the county ran to follow up with people who were hospitalized for mental

illness. It was the goal of the program to do this within 7 days (which was the CCO's P4P measure). To run this program, they had real-time data of hospital admissions and tracked their program team's follow up activities, including if they got people into outpatient care. This kind of process/program data could be a good monitoring source for the related HEDIS measure 7-day Follow Up After Hospitalization for Mental illness.

4. EHR Data – The SIT will work directly with providers so that they themselves are being trained to use their own data to monitor their day to day performance. The ACH is hopeful that this could be the source of performance monitoring at a provider level but will process with cautious as this solution provides an additional upfront burden on providers, though would provide long-term use for providers.

5. MCO Contract Measures: MCO's already monitor provider performance on many P4P measures. How do we best leverage this work? To date, MCO's have expressed PCACH that this option is not preferable.

Project Sustainability

PCACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation. PCACH is facilitating new linkages between providers and CBOs and expects that these partnerships will become part of the infrastructure and an accepted way of doing business. In addition, PCACH is working with providers to move from volume to value to transform practices. To do this, PCACH and its SI Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers to help them meet established success measures and outcomes.

PCACH's Community Resiliency Fund is a key sustainability strategy for our integration work. During the Demonstration, PCACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resiliency through social determinant investments and key policies and system changes for overall population health.

Other strategies that might support long-term project sustainability include:

1) Shared Savings: We will use our data and evaluation capabilities to capture shared savings, with a portion of those savings supporting the PCACH and a portion re-invested in the community via the *Community Resilience Fund* or other mechanisms.

2) Strategic Improvement Services and Service Line Contracting: The services we provide in support of implementation can eventually move toward fee-based or per member per month (PMPM) support models, especially as our work spreads to other populations and settings. Data from our impact evaluation can be used to help us develop appropriate pricing models for these services.

3) Philanthropy: We will actively engage with local, regional, and national foundations to support our innovative integration and population health work.

4) Grants: Integration is of paramount interest to health policymakers nationally. As we develop and implement innovative approaches to improve bi-directional integration, we can attract interest from local or national funders interested in using our work as an opportunity to test those innovations and potentially spread them to other states.

5) Partnerships outside the Medicaid market: As our work expands beyond the Medicaid market, we will leverage emergent opportunities to engage with the business sector or other partners who may be interested in applying our model within the context of their workforces or other populations of interest.

Impact Beyond MTP

Washington is moving to full financial integration for physical and behavioral health by 2020, and Pierce County has finalized an agreement with HCA to move toward mid-adopter fully-integrated managed care (FIMC) plans by 2019. Financial integration alone will not result in the improved outcomes. However, to achieve the Triple Aim (or the Quadruple Aim we have adopted in Pierce County), we must also achieve clinical care integration. The investments made by PCACH to support bi-directional integration in 2017 and 2018 will position the region and its partnering providers to provide a clinically integrated system of care wherever an individual seeks care in preparation for full financial integration in 2019.

2B: Community-based Care Coordination

Rational for Selection and Expected Outcomes

This project will establish a regional Pathways Community HUB[66] to provide community-based, culturally competent and person-centered care coordination for identified vulnerable populations in Pierce County. "The HUB model is all about risk. It is about the comprehensive identification and reduction of risk. The HUB is also about building infrastructure for communities to be able to use resources more efficiently and effectively to address risk and improve outcomes"[67] This model is evidence-based and nationally endorsed for the assessment and coordination of services that are critical for improving health outcomes, including medical (e.g., physical, behavioral, substance abuse and oral health), social, environmental and educational services. Expected outcomes with be PCACH's achievement of the quadruple aim: better care, less cost, better member experience for the target population, better provider experience.

Together with our diverse partnering providers, PCACH chose the Pathways Community HUB Model[68] with an initial target population of pregnant women. In subsequent phases, we will expand our target populations to address additional regional health priorities.[69] Through the regional health needs inventory, the severity of service fragmentation and the impact of multiple social determinants on the health of Medicaid enrollees is evident. Overall, 12.4 percent of Pierce County residents live in poverty.[69] Data from 2016 show that 5.8 percent of Medicaid enrollees in Pierce experience homelessness.[70]

Medicaid patients in the region do not always receive needed follow-up care. Only 71 percent of Pierce enrollees received follow-up after hospitalization for mental illness in 2015, compared with the state average of 80 percent.[71] Pierce County is one of the lowest performing regions in the state for Mental Health and Substance Use Treatment Penetration – meaning that Medicaid enrollees with a care need don't always receive services.[72] In 2013-2015, areas in this region had the highest rates of preventable hospitalizations in the state. The 29th district had 1,299 potentially preventable hospitalizations per 100,000 persons, about double the state average. This suggests that there are primary care access and utilization issues – patients in the region may not have access to the preventive care they need to manage chronic conditions like asthma or diabetes.[73]

Pierce County's rate of Emergency Department (ED) Utilization is 52 per 1,000-member months for Medicaid enrollees with significant disparities across certain subpopulations. Adults with co-occurring mental health and substance use disorder diagnoses are more than four times as likely to have three or more ED visits in a year. Adults with diabetes are more than five times as likely to have more than three

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[66] AHRQ Publication No. 15(16)-0070-EF Replaces AHRQ Publication No. 09(10)-0088 January 2016.

[67] Sarah Redding, MD, MPH Director Pathways Community HUB Institute, 2016.

[68] The Rockville Institute, https://pchcp.rockvilleinstitute.org/hub-model, 2017.

[69] HCA RHNI Starter Kit

[70] HCA ACH Historical Data

[71] HCA ACH Historical Data

[72] HCA ACH Historical Data

[73] Office of Financial Management; Potentially Preventable Hospitalizations by Legislative District, July 2017

ED visits in a year.[74] Finally, only 34.8 percent of all eligible Medicaid members are using dental health services, compared to the statewide rate of 38.2 percent.

PCACH's Pathways Community HUB is an evidence-based national model that will promote care coordination across the continuum of health services for Medicaid beneficiaries, ensuring that those with complex health needs are connected to the interventions and services needed to improve and manage their health. Pathways Community HUB is a direct link to value-based payments by supporting the selected population through pathways that ensure providers and population access services appropriately. The Pathways Community HUB will be the community's driving force for breaking down silos, coordinating needed supports beyond the walls of health care, and advancing improvements in overall health and disparities. Ultimately, we expect that the Pathways Community HUB will serve as a PCACH anchor that creates cohesion and linkages across Medicaid—including all of the region's demonstration projects—and the community's overall health system transformation.

PCACH will serve in the role of the Pathways Community HUB[75] (Attachment 105 Rockville Institute), providing standard training, development of workflows, and critical tools such as the HUB information technology (IT) platform to track and share information. PCACH will support partnering organizations by: centrally tracking the progress of individual clients, monitoring the performance of individual workers, assessing the outcomes of priority populations, and evaluating overall organizational performance. The HUB will work closely with Care Coordination Agencies (CCAs) and referring organizations to ensure that individual's health risk factors are addressed through all 20 standardized Pathways that attend to an individual's needs by connecting them to a range of community-based health and social services.

The Pathways Community HUB will support sustainable health system transformation for targeted populations through the following mechanisms:

1. Deepen experience and skills with community-level care coordination that will build capacity for addressing directly the social determinants of health, reducing duplication and fragmentation across the health system, and ultimately empowering individuals to be healthy.
2. Build experience with value-based payment methodologies (i.e., payments based on outcomes within the HUB model) that will help to drive models of sustainable financing for community health approaches that improve long-term health outcomes and reduce health system costs.
3. Investment in the development of a Pathways Community HUB IT infrastructure (i.e., through a contract with CCS), which will allow for interoperability at a community and cross-systems level, allowing for better care, improved tracking of outcomes, and reduced fragmentation.

Coordinated and Not Duplicative

To ensure coordination and avoid duplication, PCACH has engaged a broad set of stakeholders and partners across Pierce County as part of the planning process, including hospital systems, behavioral health providers, community-based organizations, representatives from county government, managed care organizations (MCOs) and the criminal justice system. PCACH has worked closely with community members and various PCACH councils and workgroups to complete an environmental scan and community mapping exercises to identify potential areas of overlap or duplication. In addition, PCACH staff met with the Pierce County Perinatal Collaborative in September 2017 to share information about

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[74] DSHS RDA Measure Decomposition
[75] The Rockville Institute, https://pchcp.rockvilleinstitute.org/hub-model/

the Pathways Community HUB and identify any potentially overlapping services that would benefit from additional coordination.

Through the environmental scan, mapping exercises and stakeholder input, we have identified two key programs in the county that have a shared focus on improving outcomes for pregnant women through service coordination: The Maternal Services and Supports (MSS) Program and Nurse Family Partnership (NFP). We will continue to work with each of these partner programs to understand eligibility, share data, and to identify opportunities that ensure ongoing coordination during the HUB pilot. Together, we expect that MSS, NFP and Pathways can leverage our shared tools and reach to improve birth outcomes in Pierce County in a complementary fashion.

Anticipated Project Scope

The Pierce County Pathways Community HUB will be implemented as an initial pilot targeting 200 pregnant women in DY 2. This pilot includes an anticipated cohort of seven community health workers (CHWs) serving as care coordinators across four contracted CCAs. During this initial pilot, HUB partners will build experience with budgeting, value-based payment methodologies, tracking outcomes, and building sustainability as we prepare to expand scope in DY 3.

As expansion occurs, we as region have also prioritized Community Paramedicine as a key ingredient for diversion and transitions of care. Paramedics provide critical care outside of the health care institution and are highly trained to handle many different situations.   There is a clear role for Community Paramedicine programs within the Pathways Community HUB. With the patient's best interest in mind, we will ensure that the Pathways Community HUB supports a coordinated team of trusted professional working towards the best outcome.

Anticipated Target Population

In DY 2, The Pierce ACH Pathways Community HUB will reach a total of 200 pregnant women as part of the initial Pathways Community HUB pilot. The Pathways Community HUB Model already has an existing, strong evidence basis for improving outcomes for pregnant women and infants in other states. Targeted outcomes of interest for the initial PCACH pilot include improvements in prenatal care, overall birth outcomes and reduction of disparities (i.e., across race, ethnicity, language and geography). Metrics that are being considered for the Pierce County Pathways Community HUB include:

- Low birth weight
- Prenatal care in the first trimester
- Breast feeding
- Fetal, infant and maternal mortality
- NICU admissions
- C-section prior to 39 weeks
- Teen pregnancy
- Unintended pregnancy

The initial target population for this project is pregnant women. A primary outcome for the project will be to ensure that pregnant women enrolled in the program deliver healthy birth weight babies. Low income pregnant women and new mothers may have an array of health and social service needs, and may be interacting with multiple systems and sectors. The Pathways Community HUB project provides

structures to connect enrollees to resources they need to address health needs, as well as the underlying social factors that impact health, such as housing or transportation. Care coordinators will assist enrollees in navigating complex health care systems, and navigating across different sectors, reducing the burden on the patient to effectively engage in their own health care and health outcomes. By coordinating care for the entire family, the Pathways Community HUB reduces duplication of services, which will also reduce the burden on enrollees to manage contacts from multiple care coordinators.

By DY 3, the HUB will expand to reach an additional 1,825 individuals served, including new target populations, such as individuals with opioid use disorders and individuals with co-occurring behavioral health disorders and chronic conditions. This expansion will necessitate an estimated 50 CHW care coordinators.

Table 9. Anticipated Individuals to be Served by the Pierce County Pathways Community HUB

Initiative	Population Type	Potential population	2017 - DY1	2018 - DY2	2019 - DY3	2020 - DY4	2021 - DY5	2022
Opioid Injectors	Adult	3,000			150	300	400	500
Opioid Injectors	Pediatric	400			75	100	150	200
Opioid Prescription	Adult	6,000			500	750	1,000	1,000
Opioid Prescription	Pediatric	600			50	75	100	100
Pregnant - Hi Risk	Pregnant	3,850		200	300	450	675	1,000
Bidirectional/Co-occuring Behavioral and Chronic	Adult	70,000			750	1,125	1,688	2,531
Total		-	-	200	1,825	2,800	4,013	5,331

Involvement of Partnering Providers

Prioritization of the Pathways Community HUB model has been achieved through deep engagement with stakeholders, including each of PCACH's councils and workgroups and through several public meetings. PCACH has also established a Care Coordination Advisory Workgroup to engage a broad spectrum of partnering providers in the identification of regional needs and development of the Pathways Community HUB project to date.

Altogether, close to 200 individuals from multiple sectors have been engaged in the planning process, including managed care organizations (MCOs), community members, medical providers, substance use disorder providers, emergency medical services, housing, criminal justice, public health, early learning, and more. Ultimately, stakeholders across Pierce County have agreed that the Pathways Community HUB model is the right tool to address the fragmentation across health care, social, educational and community services that create barriers for health improvement, reduction of health care costs and PCACH achievement of health equity in the community.

Level of Impact

PCACH has used a multi-phase process to identify the target population for the initial Pathways Community HUB pilot. With the help of the Center for Outcomes, Research and Education (CORE) and the PCACH's Data & Learning Team, a "Pulse" survey was disseminated that asked council members to rank priority populations according to need and potential for impact. Subsequently, the following three criteria were applied to the 6-8 identified populations to isolate as the best-suited target population(s)

for the initial HUB pilot:

- Need: Does the priority population disproportionately experience poor health outcomes? Are there subgroups within the population that experience disparities? Is there a gap in existing services that could effectively address these outcomes?
- Impact: Is there strong potential for the project/intervention to improve outcomes for the population in 2-3 years? Is the priority population large enough for improvements to drive community-wide outcomes?
- Data feasibility: What data currently exist to explore the priority population, track outcomes, and evaluate impact?

A deep look at data pertaining to pregnancy and birth outcomes shows that Pierce County fares worse than the rest of the state in many ways. Teen pregnancy rates are higher that the state average, especially for older teenagers. The overall teen pregnancy rate in Pierce County is 31.95 per 1,000 females ages 15-19, and 63.24 per 1,000 for females aged 18-19. With regards to access to prenatal care, 64 percent of pregnant Medicaid members initiate care in the first trimester, as compared to 80.1 percent of non-Medicaid pregnant women. The Pierce County infant mortality rate is 5.51 per 1,000 live births compared to the state rate of 4.66 per 1,000 live births. Finally, while low birth weight rates are similar to the state average at 6 percent, Tacoma Pierce County Health Department equity maps demonstrate significant variation based on geography, race and ethnicity.

As a result of these analyses and application of PCACH selection criteria, pregnant women have been identified as the target population for the initial HUB pilot. A sub-focus on women with substance use disorder (particularly opioid), and non-white women, will be emphasized to improve outcomes for those pregnant women facing the greatest disparities. Once the community has assessed the initial HUB pilot, the HUB target populations will be expanded to include individuals with co-occurring behavioral health and chronic condition diagnoses as well as individuals with substance abuse disorders.

Health Equity

Health equity has been a foundational element in all matters of project design for PCACH. To ensure that individuals facing the greatest health disparities inform the community needs assessment and improvement opportunities, PCACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of Pierce County Medicaid members.

PCACH's Community Pathways Community HUB is expected to be an important thread across all demonstration projects that contributes to the pursuit of health equity. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries' access to culturally and linguistically responsive care. Furthermore, commitment to health equity was incorporated as a key question in the CCA RFP process. Based on thoughtful proposal review with participating community representatives, the four CCAs that will move forward to contracting are trusted community partners that have deep experience in supporting the diverse cultural, linguistic and geographical needs of Pierce County members.

Lasting Impacts and Overall Benefit

Through the implementation of a Pathways Community HUB, PCACH expects to gain deep experience with community-level care coordination, strengthened partnerships across referring entities and care

coordination agencies, and a heightened experience with tracking data and outcome-based payment methodologies intended to create long-lasting system change to improve population health in our community. Pathways ensures payment for care coordination is based on outcomes instead of activities, making a direct link to value and supporting the move from volume-based payment to value-based payment.

Partnering Providers

Serve a Significant Portion of Medicaid

PCACH has convened and collaborated with partnering providers serving Medicaid populations throughout the region during HUB development. This has included RHIP, PIP, CVC and BOT meetings, as well as ad hoc presentations based on interest and requests. Based on analysis of provider claims data provided by HCA, PCACH is working with partnering providers representing the highest Medicaid billers in each major setting (primary care, mental health/substance abuse, inpatient and ED). Across all settings, partnering providers engaged to date are responsible for the majority 90 percent of Medicaid claims in the region. We will continue to engage additional partnering providers providing a significant portion of Medicaid services in the region and not yet engaged in this work.

Commitment to Serving Medicaid

By Spring 2018, PCACH will secure contracts with CCAs that will include a commitment to PCACH's Rules of Engagement and to serving the target Medicaid populations. Additional contracts will be secured with HUB referring organizations by March of 2018. Our plan for real-time monitoring and continuous improvement will also provide ongoing oversight of providers to ensure that they are serving Medicaid populations and implementing strategies that are working to reach the desired outcomes for the HUB's target Medicaid populations.

Process for Engagement

PCACH has established a Care Coordination Advisory Workgroup to engage a broad spectrum of partnering providers in the identification of regional needs and development of the Pathways Community HUB project to date. In 2018, our deep partnerships with providers, health systems, community-based organizations and other stakeholders will remain a focus throughout the planning period. PCACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with city, regional, state and local officials; including city and county council, county executive and regional representatives and senators.

As mentioned previously, when expansion occurs we have identified Community Paramedicine as a key ingredient for community engagement and the connection between social services. To understand how paramedics would fit into the HUB approach, let's take an example of an individual who repeatedly calls for non-emergent issues. In a HUB situation, the paramedic could come to the home and determine if there is a reason to transport the patient to the hospital. If there is no emergency and the paramedic's agency was contracted with the HUB, then the initial enrollment process could be completed in the home. The paramedic would obtain a signed release of information and begin collecting data. Key information obtained during this first visit would be the demographic profile and initial checklist. Screenings could be completed as well – PHQ9 for depression, patient activation measure, home safety checklist, and others. The paramedic would also be able to do clinical monitoring in the home, if necessary.

The paramedic may decide how long to continue the home visiting relationship with the patient. In some situations, after a few home visits, the paramedic may decide to transition to another community-based care coordinator to work on social issues. In this situation, during the last visit, both the paramedic and care coordinator would visit the client and a warm hand off would occur. For medically fragile individuals, the paramedic may complete ongoing home visits to assess clinical parameters. In this case, the care coordinator may visit every two weeks, and the paramedic may visit every six weeks.

The advantage to being involved in the HUB is that the work completed by the paramedic could be billed to payers contracted with the HUB. Paramedics can be key members of the patient's health care team. The HUB would allow for clear documentation of care coordination services provided and a mechanism for payment. Payments for completing checklists, screening tools and Pathways could compensate for the time spent in a patient's home. The HUB could monitor and track the frequency of calls to 911 as well as follow-up for medical appointments. The goal would be to see a switch from non-emergent acute care to ambulatory and preventive services.

As Pierce County moves toward fully integrated care, local fire jurisdictions, emergency management services, state and local health and social service departments are prepared to partner for the augmentation and scale of Community Paramedicine in our region.

MCOs Expertise

PCACH has been working closely with MCOs to leverage their expertise, identify areas of alignment, and ensure there is no duplication. MCOs have been active participants across all PCACH councils and workgroups. Through these roles, MCOs have directly informed discussions and decisions pertaining to project selection, target populations, and the PCACH rules of engagement for partnering providers.

PCACH leaders have also been actively engaged in collaborative conversations with MCOs, HCA representatives, and other regional ACHs to explore how Community HUBs and Health Homes can be coordinated and complement one another. In addition, PCACH and MCOs have identified the following opportunities for deepened and coordinated work beyond the specifics of HUBs and Health Homes, including: 1) assessment and support to expand provider readiness for VBP contracts, 2) optimization of data sharing to inform monitoring and continuous quality improvement, 3) provider support regarding utilization of data to inform quality improvement efforts, and 4) provider support regarding adoption of effective strategies to improve patient engagement.

Regional Assets

The PCACH team brings extensive knowledge about the Pathways Community HUB Model and has met repeatedly with the model developers. We recently travelled to Chicago to get a deep dive into budget forecasting and sustainability for HUBs and have also met with the Rockville Institute to fully understand the certification process. Finally, PCACH leaders have invested a significant amount of time and resources to working with Care Coordination Systems (CCS) early in the development of the HUB's IT platform that will be critical for its success.

Existing regional partners in Pierce County represent additional critical assets for the development of the Pierce County Pathways Community HUB. Informed by discussions with the Community Voice Council, PCACH created a Request for Proposals (RFP) process that was broadly disseminated. After review of the proposals with community partners, PCACH has identified four CCAs that have committed to serving the Medicaid population and represent geographic and cultural diversity across

the county to ensure a broad reach and ability to address Pierce County's health disparities. The initial, expected CCAs include:

- Sea Mar Community Health Centers: a community-based organization committed to providing quality, comprehensive health, human, housing, educational and cultural services to diverse communities, specializing in services to Latinos. It served 23,879 unduplicated patients in Pierce County during fiscal 2017. Sea Mar will dedicate up to 2.0 FTE (CHWs) to the Pathways Community HUB.

- Korean Women's Association (KWA): a culturally responsive and multi-lingual organization that provides an array of clinical and community services and excels in providing person-centered care coordination services. 65 percent of KWA's Pierce County clients reside in Tacoma, while 35 percent reside in rural/suburban areas of Pierce County. KWA's Community and Behavioral Health department houses its care coordination services and serves 1,000 clients in Pierce County annually. Of those clients, 65 percent are enrolled in Medicaid, 40 percent are Asian Pacific American, 25 percent are African American, 20 percent are Latino American, and 15 percent are Caucasian American. KWA will commit up to 4.0 FTE to the Pathways Community HUB.

- HopeSparks Family Services: a recognized leader in behavioral health, early intervention, kinship care, home visiting, eating recovery and parent education. It comprises five core behavioral health programs that serve children and families in Pierce County who face trauma, abuse and overwhelming life challenges. During 2016, HopeSparks served 3,343 children and families, including an estimated 100-150 pregnant women enrolled in Medicaid. HopeSparks will commit 1.0 FTE to Pathways.

- Community Health Care: offers primary medical and dental care, pharmacy and behavioral services as well as specific services in Pediatrics, Women's Health, Maternity Support Services, and Substance Abuse Treatment and Enabling Services. In 2016, a total of 44,329 patients were served in Pierce County, 70 percent of whom are enrolled in Medicaid, representing 20 percent of Pierce County's Medicaid Population. 50 percent of clients served at Community Health Care are Caucasian, 1 percent Native American, 14 percent African American, 5 percent Asian, 5 percent Hawaiian/Pacific Islander, 7 percent more than one race, and 18 percent unreported. 23 percent of Community Health Care's clients are Hispanic. Community Health Care will commit up to 8.0 FTE to the Pathways Community HUB.

As previously highlighted, each of these CCAs are committed to health equity and currently provide culturally and linguistically responsive services to meet the diversity of PCACH resident's needs. Every one of these organizations already utilizes CHWs as part of their workforce structure and are adept at integrating CHWs into their overall team.

Anticipated Challenges or Barriers

CCA preparedness: PCACH has identified multiple potential challenges that must be addressed to ensure the successful implementation and impact of the Pathways Community HUB model in Pierce County. The first anticipated challenge is the expected learning curve for CCAs who are used to providing care coordination services in a different manner (i.e., not previously using community-level care coordination or Pathways). Participating CCAs will need to learn new ways of assessing data, working with external

partners, and getting paid based on outcomes versus services provided. These organizations will also have to adapt to being held accountable by an external HUB organization.

Data platform and interoperability: Another potential challenge for improving outcomes and lowering costs via the Pathways Community HUB model in Pierce County is the very specific HIT/HIE needs of the model. The HUB technology/data platform must allow for accurate and timely documentation for all of the Pathway activities. In addition, the data platform must optimize interoperability with statewide and regional data systems to ensure maximal effectiveness in improving health outcomes.

Finance model: Pathways is a component of value-based payment and supports the shift from volume to value. However, sustainability is dependent on the state and payer's collective willingness to engage in designing a mutually agreed upon funding model for Pathways.

Mitigating Risks and Barriers

The PCACH is working hard to mitigate risks for successful implementation and/or effectiveness of the Pathways Community HUB through the following strategies:

> CCA preparedness: PCACH is working with expected pilot CCAs to ensure there are clear expectations and understanding for how the model works, including the specific role of the CCA, value-based payment methodologies, and expectations. This additional step prior to contracting will help to ensure a shared understanding of roles, responsibilities and key model components to ensure a positive working relationship and ability to maximally improve health outcomes for Pierce County. Starting small with an initial pilot will help to gain experience and meaningfully address initial barriers that can be addressed prior to scale-up.

> Data platform and interoperability: PCACH has chosen to work with Care Coordination Systems (CCS) to develop the Pathways Community HUB data platform. CCS has already developed a platform specific to the Pathways model and therefore brings tremendous experience to the needs of a new, developing HUB. Additionally, CCS has worked with multiple EHR systems to create some level of interoperability. Work is already underway to create linkages between CCS, EDIE, Pre-Manage, the criminal just system electronic health system, and beyond.

> Finance model: PCACH will continue our efforts with MCOs to arrive at a mutually agreeable and feasible financing mechanism for the Pathways Community HUB. We will also continue to advocate for the inclusion of Pathways Community HUB outcome payments in Total Cost of Care, so it will be included in premium. Pathways is consistent with paying for outcomes and value – it should be included as an expense covered by Medicaid premium.

Monitoring Implementation Progress

PCACH is building a project monitoring and continuous improvement infrastructure and process to support the Demonstration project portfolio and a community-wide system of care working collectively to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, PCACH Strategic Improvement Team, and reporting at multiple levels including providers, community, ACH governance, and HCA reports.

Figure 22. Process for Monitoring and Continuous Improvement
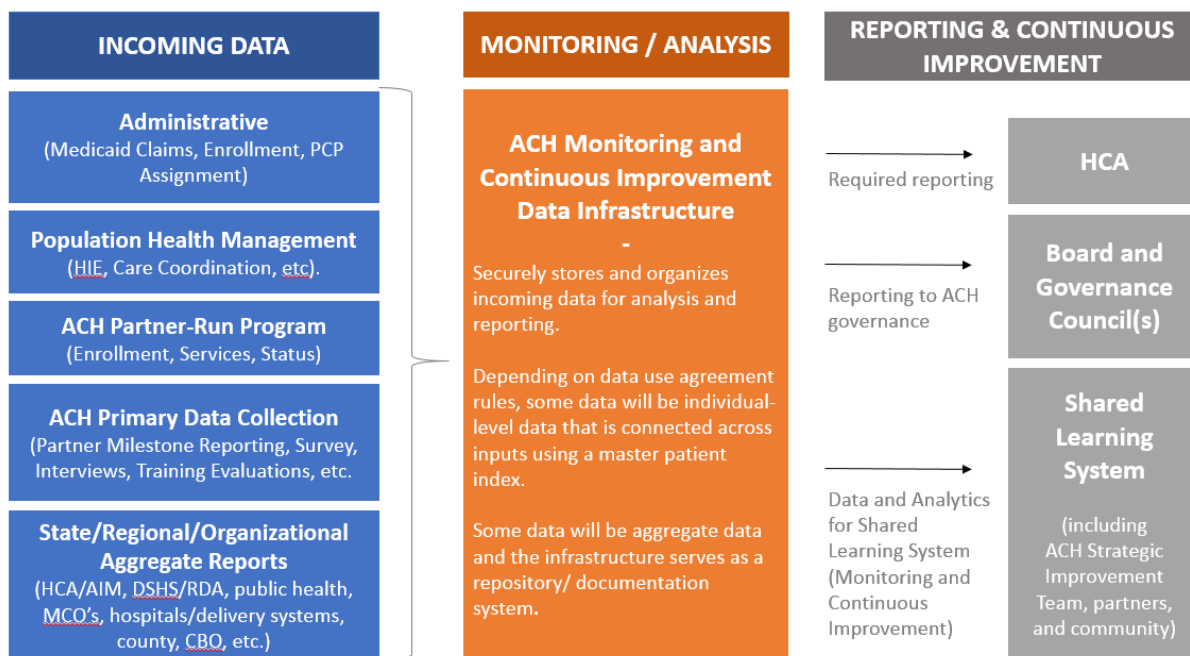
The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards or) and will build upon "point of care" population health management system inputs needed for projects. Among the incoming data in Figure 22 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data identified by the Opioid Workgroup and PCACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread.

PCACH has contracted with the Providence Center for Outcomes Research & Education (CORE) to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, serving as a HUB for all quality and monitoring activities.

Monitoring Continuous Improvement

Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by PCACH with clear lines of communication and accountability between partnering providers, PCACH staff, CORE, and PCACH's governance body.

If timelines still cannot be met, PCACH will communicate a plan back to the state regarding reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies will be shared with other programs where appropriate.

The PCACH Strategic Improvement (SI)Team will drive quality improvement strategies with providers. The SI Team will consist of the director of strategic improvement who will oversee a team of improvement advisors. This team will create and run a unified system of rapid cycle feedback and quality improvement across all the organizational partners and to ensure the successful progress toward

milestones and outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process. The SI Team will be responsible to report findings to the Care Coordination Advisory Workgroup, the councils and board.

In addition, the Pathways Community HUB model and data collection tool using the CCS platform will be explicitly developed to allow for real-time assessment of Pathways outcomes and provide PCACH the opportunity for addressing challenges as they arise. The system will be informed by key planning inputs that better position PCACH to invest in and provide supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and ACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the Demonstration for each project area.

PCACH has developed a Strategic Improvement infrastructure that consists of improvement advisor that provide support for providers – across all projects – to achieve continuous improvement. The following content on the key general supports will apply across the board for projects, but project-specific supports like the exact trainings, tools, and technical assistance will vary by project and provider and will unfold as these teams undergo a process for developing specifics. The following content outlines the general supports and approach, the process for developing specifics (including some example specifics), and additional thinking and work done to date related to this topic.

Key general supports for partnering providers to achieve continuous improvement include:

1) PCACH-funded Data Analytics, Performance Monitoring, and Quality Improvement Processes and Programming including the following examples of key general supports:

- Strategic advisement and technical assistance on defining project metrics
- Strategic advisement and technical assistance on data collection best practice and methods for tracking metrics and ensuring provider proficiency at reporting on required PCACH and MTP level reporting requirements (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and regularly report on a monthly, quarterly and annual basis
- Strategic advisement on how quality and other metrics are measured and related technical assistance to improve reporting and documentation process
- Strategic advisement on how to improve quality outcomes and tools for achieving those outcomes
- PCACH-wide performance monitoring dashboards
- Where possible, data analysis of performance to understand what's driving performance rates and forecasting related to hitting targets
- Ensuring participating providers and partners have pay for reporting tools and capabilities in place
- Assessments on connectivity with various partners data including administrative data, MCOs, CCS (Pathways) platform and Chronic Disease, etc. for data and pull together (with CORE's oversight) for regional dashboard
- Ensuring shared learning system is accelerating implementation, spread, and scale-up of innovative approaches to improving health outcomes
- In addition to the Data Analytics, performance Monitoring, and Quality and Continuous

Improvement, PCACH is funding Strategic Improvement Team consisting of Improvement Advisors and Continuous Quality Improvement workgroup. These resources will leverage the data provided to guide their efforts in providing technical assistance, practice coaching, and trainings to the providers.

Identification for Initiatives or Strategies Not Working

The comprehensive shared learning system, PDSA continuous improvement process and CCS platform will support PCACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes.

PCACH-funded Strategic Improvement Team (SI Team) and Quality & Continuous Improvement Workgroup (QCI) will provide support for rapid cycle feedback and quality improvement (Improvement Framework and Science of Improvement model, see Attachment 206 and 110 provided in our original project plan submission). The following are examples of key general supports:

• The Strategic Improvement Team will work together with our provider practices and partners to ensure that all improvement efforts include, IHI's Science of Improvement steps:

- o A clear, measurable aim (focused on MTP projects are at the center - i.e. integration, opioid, chronic disease, transitional care, diversions)
- o A measurement framework in support of reaching the aim
- o A clear description of the ideas (content) and how these ideas are expected to impact the results (the causal pathway from changes to desired outcomes)
- o A clear description of the execution strategy (what will be done to ensure reliable adoption of the content?)
- o Dedication to rapid testing (PDSA cycles), prediction, and learning from tests
- o Understanding, describing, and visualizing systems (e.g., using a process map or value stream map)
- o Learning from variation and heterogeneity: Use of time-ordered data to detect special cause and improvement Understanding why results differ by location (ward, organization, etc.)
- o Application of behavioral and social sciences
- o Application of pay for reporting tools for improvement and waiver project reporting to enable payment and progress toward improvement
- o Building science-based improvement capability at provider, team, clinic-wide and system level
- o Ensuring quality improvement knowledge and skills are provided to participating providers and health care workforce
- o Ensuring the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
- o Providing a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results

• The Quality & Continuous Improvement Workgroup will be an external team made up of quality and clinical improvement individuals in regional partnering organizations that support the quality improvement activities associated with PCACH's transformation efforts.

- o QCI Workgroup comprised of Quality and Clinical Improvement level participants from participating providers/partners, staffed by Director of Strategic Improvement;

- o Establishment the Systems and Capacity Building Fund to provide resources for quality improvement education, training, technical assistance, education, practice improvement and support for participating providers; and
- o Adoption of Science of Improvement methodology that allow for new and innovative strategies.

Project-Specific Supports: The above content describes the general approach to supporting providers for continuous improvement. Due to the timing of writing this project plan and PCACH progress on hiring and staffing these key roles to facilitate deeper development of specifics, PCACH has not had staff in place long enough to articulate all of the project-specific measures, trainings, tools, etc. that they will provide, though PCACH was proactive at assessing each provider's specific needs, there has not been time to develop a resulting tailored QA plan.

That being said, PCACH can articulate the process by which they will develop more specific supports.

This process includes:

Phase I Partner Inventory (COMPLETE) - PCACH has completed and reviewed a starting inventory of partnering provider interests, needs, and goals as it relates to the Demonstration project areas. This Phase I Partner Inventory was a 12-page document, exploring individual organization's interest and barriers to participation in MTP. The inventory was sent out in September 2017 to more than 70 diverse types of organizations, such as clinical providers, hospital systems, behavioral health providers, EMS, and community-based organizations. PCACH received over 30 responses, with approximately 10 from clinical providers and hospital systems, 10 from behavioral health providers and 10 from community-based organizations. This information has provided a starting point for the SIT to plan specific TA, training and education.

- Phase I Partner / Provider Guided Discussions for Portfolio Development (COMPLETE) – PCACH followed up with key providers to have more in-depth discussion based on inventory responses.
- Develop and Adopt Rules of Engagement (COMPLETE) - PCACH has developed and adopted Rules of Engagement that outline expectations of providers under the Demonstration. These rules will provide clarity on specifics so that the SI Team can develop a corresponding plan for support and identifying risks.
- Phase II Partner Inventory/Assessment (Upcoming) – PCACH will conduct a formal "current state assessment" across all projects that will provide an up-to-date inventory of current state and barriers/haps to achieving future state expectations (rules of engagement) and additional conversations for the implementation design phase.
- Implementation Design Phase (Under development and deployment upcoming) – PCACH will continue to engage providers during the implementation design phase. This engagement will involve developing out a plan for quality improvement and technical assistance (a strategic improvement toolkit) needed from providers to be successful in achieve milestones and outcomes by project.

Example 1:

- Partnering Provider A identifies in their inventory that they lack the technical systems needed to fulfill required reporting for a project area.
- PCACH has a follow up guided discussion with the partnering provider to understand why these systems are not in place – documenting the barriers and supports needed. This information goes

into PCACH's planning process, of all provider barriers and supports that feed into PCACH's Strategic Improvement Team's

- PCACH developed out and governance structure and then the Board adopted the Rules of Engagement so that there are clear required expectations of that provider to fulfill the reporting while simultaneously co-developing with the provider- in planning and further development the implementation design phase, a plan for providing assistance to build up the providers capacity to fulfill reporting requirements. This could include strategic advisement and TA on tracking the right inputs and extracting reports from their existing systems.

Real-Time Data / Day-to-day Performance

To date PCACH has explored options for data inputs for monitoring and quality improvement including proxy measures for performance monitoring and QI when ideal inputs may be unavailable. PCACH's goal is to identify data sources and/or processes that will help PCACH track provider/partner progress and/or activities that will lead to improvement for the pay for performance measures.

Problems – Access to Timely Data/Reports for Performance Monitoring and Analysis many of PCACH pay for performance measures will be subject to claims lag and other processes that will prevent PCACH from being able to monitor performance progress on these metrics in a timely manner. PCACH will also need access to data or reports on the metrics that will allow them to analyze the data to do things like identify disparities by population (are there specific populations that have lower rates of well child visits?), geography (are there differences in rural or urban communities on well child visits?), or provider (are there differences by clinic in well child visit rates?)…and the interaction of these factors that could lead to identifying more complex issues.

Example: A key input for monitoring and QI could be Administrative Data on Medicaid Population through Medicaid Claims / Enrollment – the data source for the majority of the pay for performance metrics. Though this information is not real-time, it could be used for metrics forecasting. Providence CORE has a metrics and forecasting team that specializes in forecasting metric rates, though again, as PCACH's data analytics vendor, PCACH has been told that they cannot put agreements together to give their data analytics vendors access to these data for monitoring and QI.

Possible Solutions – Develop Proxy Measures and Data Sources: Despite barriers to access to data, PCACH will continue to work through the metrics and identify data sources and processes that could be explored as proxy sources (e.g. which health care settings are key to this metric? which project area implementation steps or program workflows and data that could have QIP metrics added to them?).

Examples:

1. ED Visits: Could a region reliably monitor ED visits through EDIE data as a proxy data source for the P4P ED measures? As previously mentioned, the challenge of trying to translate EDIE data to a proper rate per member or rate per 1,000- member months would take some thinking. Since most of the performance measures have layers of criteria for inclusion and exclusion (especially those that rely on coverage or other utilization in claims) that a proxy data source may lack, there will be some instances where this will be more worthwhile/feasible than others. Continuing with this example, would we be able to explore EDIE data for patterns by population, geography, and/or emergency department? And for an ACH that might be interested in a monitoring approach that has a public surveillance lens to it – that ACH might leverage data like these to do more real-time

community wide monitoring of emergency department use trends.

2. Clinical Processes: identify clinical processes that could be adapted and tracked to ensure that we see change within clinics that ought to lead to performance improvement. This falls perfectly into the world of QI.

3. Measures of Care Coordination: I mentioned that measures of care coordination will often have other systems where activities are tracked that could serve as process data. For example – in Oregon there was a program that the county ran to follow up with people who were hospitalized for mental illness. It was the goal of the program to do this within 7 days (which was the CCO's P4P measure). To run this program, they had real-time data of hospital admissions and tracked their program team's follow up activities, including if they got people into outpatient care. This kind of process/program data could be a good monitoring source for the related HEDIS measure 7-day Follow Up After Hospitalization for Mental illness.

4. EHR Data – The SI Team will work directly with providers so that they themselves are being trained to use their own data to monitor their day to day performance. The ACH is hopeful that this could be the source of performance monitoring at a provider level but will process with cautious as this solution provides an additional upfront burden on providers, though would provide long-term use for providers.

5. MCO Contract Measures: MCO's already monitor provider performance on many P4P measures. How do we best leverage this work? To date, MCO's have expressed to ACH's that this option is not preferable.

Project Sustainability

PCACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation. PCACH is facilitating new linkages between providers and CBOs and expects that these partnerships will become part of the infrastructure and an accepted way of doing business. PCACH has been working hard towards setting up the infrastructure and technical assistance to help move partners in the region towards paying for quality and value over volume. At the outset, we will be directly involved in supporting CCAs during as they adapt to new payment methodologies as part of the Pathways Community HUB model.

PCACH has been partnering with the Pathways Community HUB Institute (PCHI) during the HUB planning phase, and we have participated in several phone calls with payers around the financing model for the Pathways Community HUB model. Detailed education has been provided around how Outcome Based Units for the Pathways Community HUB model were developed, how current contracting strategies currently work in Ohio, and case studies on client types within the HUB. Ultimately, HUB certification standards require that contracts with the HUB must have a minimum of fifty percent of all payments related to an individual's intermediate and final Pathway outcomes. Additionally, national certification standards require a minimum of two payers. To achieve both these national certification standards, our HUB staff and Strategic Improvement (SI) Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers to help them meet established success measures and outcomes.

Finally, PCACH's Community Resiliency Fund is another key sustainability strategy. During the Demonstration, PCACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resiliency through social determinant investments and key policies and system changes for overall

population health. The Community Resiliency Fund will deepen and strengthen existing investments as well as provide a model for future investments, one that builds off PCACH's infrastructure and vision and is adaptive to the changing landscape.

Impact Beyond MTP

Through our work, PCACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and to the commercial market. We expect that our deep collaboration with providers, CBOs and other stakeholders will lead to long-term and effective transformation and set a standard for the health landscape in our region and our state.

3A: Addressing the Opioid Use Public Health Crisis

Rational for Selection and Expected Outcomes

Pierce County ACH (PCACH) proposes a multi-sector, multi-pronged approach to address the opioid crisis in our county. Working closely with our partners, we have designed a project with targeted strategies to benefit Medicaid beneficiaries (adults and youth) who use opioids, particularly those with Opioid Use Disorder (OUD) who are not receiving Medication Assisted Treatment (MAT). We seek to decrease the number of Medicaid beneficiaries who use opioids through preventive efforts, ensure those who are using opioids chronically have ready access to MAT and do not transition to injecting heroin, and ensure that those who are using heroin have access to harm reduction services and recovery supports. Whether using prescription opioids or heroin, all Medicaid beneficiaries will have access to naloxone and overdose prevention training, as well as community-based care coordination to support linkages to recovery programs, housing, transportation, food, and other social determinants of health.

Objective 1: Prevent inappropriate opioid prescribing and reduce the use of opioids without a prescription or misused with a prescription

- **Strategy 1.1:** Across care settings and in partnership with PCACH, providers will implement the 2015 AMDG Guidelines for Prescribing Opioids for Pain, the Washington Emergency Department Opioid Prescribing Guidelines, and/or the Substance Use During Pregnancy: Guidelines for Screening and Management.
- **Tactics:** Together, PCACH and our partners will:
  - Assess the readiness of providers to implement prescribing guidelines, support shared learning and training opportunities, develop quality and continuous improvement supports for implementation, train to reduce the stigma associated with opioid use disorder (OUD), and improve joy in work across settings
  - Implement system supports and training to identify patients with OUD, monitor patients on high doses of opioids and/or sedative hypnotics, reduce variations in prescribing, and adopt policies and procedures that limit standard post-procedural 30-day supply of medication
  - Sign up for and routinely use the Prescription Monitoring Program (PMP)
    - o MAT and recovery supports, and to avoid the transition to heroin use
- **Expected outcomes for Objective 1:**
  - Standardized approach to assess provider readiness and provide practice transformation supports to implement prescribing guidelines
  - Increase identification of patients with opioid use disorder
  - Reduce variation in opioid prescribing
  - Reduce number of new opioid users who become chronic users
  - Reduce number of patients with concurrent sedative prescriptions
  - Reduce number or patients who transition from prescription opioids to heroin use

Objective 2: Increase access to treatment for people with Opioid Use Disorder (OUD), link patients to treatment

- **Strategy 2.1:** PCACH will work with partnering providers to increase access to Medication Assisted Therapy (MAT) using one or more of the following tactics, or a combination of tactics.
- **Tactics**: Together, PCACH and our partners will:
  - Ensure providers are trained and become waivered to prescribe MAT. Providers will include

primary care clinicians, ARNPs, PAs, and obstetrics and maternal health care providers
- Evaluate and implement evidence-based programs to integrate MAT into primary care. Models we will consider include Office-Based Opioid Treatment (OBOT), the Buprenorphine HIV Evaluation and Support Collaborative Model, One Stop Shop Model, Integrated Prenatal Care and MAT, Hub and Spoke, Project ECHO, and the Collaborative Opioid Prescribing (CoOp) Initiative
- Implement telehealth approaches that include MAT prescribing
- Scale and Spread Screening, Brief Intervention, and Referral to Treatment (SBIT) for OUD
- Leverage and build on existing waiver training for residents
- Determine how training can be incorporated into the curriculum for medical doctors, physician assistants, and nurse practitioners
- Establish workgroups to identify workforce gaps in the primary care and behavioral health treatment system; develop initiatives to attract, train, and retain skilled professionals; and propose payment mechanisms that support broader access to MAT
- Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources
- Use Pathways Hub care coordinators to integrate and support team-based care across the spectrum of clinical and community-based settings and to improve:
  - Support for providers working at the top of their license; and
  - Care-coordination for patients as they transition from prescription opioid use to MAT and recovery supports and to avoid transitioning to heroin use
- **Strategy 2.2:** Implement low-barrier methadone/buprenorphine program

- **Tactics**: Together, PCACH and our partners will:

  - Establish a low-barrier buprenorphine program modeled on the University of Washington/Seattle King County Public Health Department pilot project, focusing on the successes and lessons learned through that effort
- **Expected outcomes for Objective 2:**

  - Increase community-based access to MAT for Medicaid beneficiaries with OUD
  - Increase access to integrated, whole-person care for Medicaid beneficiaries with OUD
  - Increase community-based care coordination to link people with OUD to treatment and harm reduction services

Objective 3: Prevent deaths from overdose

- **Strategy 3.1:** PCACH will work with partnering providers to increase access to naloxone in community settings

- **Tactics**: Together, PCACH and our partners will:

  - Build on the work of the University of Washington and the Washington State Department of Social and Health Services to provide additional community-based overdose prevention interventions and naloxone distribution
  - Train providers to deliver overdose prevention messages and naloxone distribution to people who inject heroin
  - Train lay responders in community-based organizations, jails, prisons, drug courts, law enforcement agencies, behavioral health and substance use disorder agencies, fire and

EMS, and pharmacies to deliver overdose prevention messages and distribute naloxone when appropriate.

- Increase capacity of syringe exchange efforts to provide overdose prevention messaging and naloxone distribution

- **Strategy 3.2:** Partnering providers will evaluate the appropriateness of co-prescribing naloxone for pain patients

- **Tactics**: Together, PCACH and our partners will:

  - Ensure providers utilize Prescription Drug Monitoring Program prompts to identify patients on high doses of opioids
  - Support providers to appropriately co-prescribe naloxone for patients as a best practice per AMDG guidelines
  - Establish a subject matter expert workgroup to imbed overdose prevention and harm reduction messaging into PCACH's community-based care coordination project
  - Work with PCACH's Strategic Improvement Team to scale and spread technical assistance regarding the Good Samaritan Law and establishing standing orders to distribute naloxone

- **Expected outcomes for Objective 3:**

  - Increase community-based access to naloxone for people who use heroin and lay responders who care for them
  - Increase primary care access to naloxone for pain patients
  - Reduce opioid overdose deaths and near deaths

Objective 4: Provide recovery supports and promote long term stabilization and whole-person care

- **Strategy 4.1:** Through PCACH's Pathways Hub, partnering providers will utilize community-based care coordination services across the continuum of health for Medicaid beneficiaries, ensuring recovery supports for patients and connections to interventions and services needed to improve access to care and address the social determinants of health
- **Tactics**: Together, PCACH and our partners will:

  - Utilize the Pathways Hub to ensure beneficiaries get the care and support they need. Care Coordinators trained and employed through the Hub will:
    - Improve access to treatment and recovery support services and promote retention and support for long-term recovery

    - Address harm reduction techniques and overdose prevention, and provide referrals to syringe exchange services for heroin injectors

    - Provide medication management services to ensure proper use of prescription medications

    - Provide family-based care addressing risk factors identified within the family as a whole

- **Expected outcomes for Objective 4:**

  - Increase number of Medicaid beneficiaries with OUD who are engaged in care coordination services through the Pathways Hub
  - Increase facilitated referrals and follow-up to treatment, recovery supports, and harm

reduction services
- Increase Substance Use Disorder penetration

In Pierce County, there are 34,517 Medicaid beneficiaries who use opioids (defined as members with at least one opioid prescription). Nearly 90 percent of those members do not have a cancer diagnosis. Twenty percent are defined as heavy opioid users and 18 percent are chronic opioid users.[76] Of the 6,558 Medicaid members with a diagnosis history of opioid misuse/dependence in the past two years, the majority are not receiving MAT. Only 10 percent (468) receive MAT with buprenorphine, while 15 percent (1,075) receive MAT with methadone.[77]

There are an estimated 2,812 people who inject heroin in Pierce County. Of those, 77 percent want to stop or reduce their use, but are not in treatment, and 23 percent are not yet ready to stop or reduce their use. In addition, in the year prior, 22 percent reported experiencing an overdose.[78] While overdose deaths are declining in Pierce County, deaths related to heroin use are increasing. (The data year for RHNI Starter Kit opioid data is FY 2016 (July 2015 – June 2016.)

Addressing the opioid crisis has emerged as a regional priority. In August 2017, the Pierce County Council declared a public health epidemic via a letter to Governor Jay Inslee and established the Pierce County Opioid Task Force to understand the crisis and make recommendations to address it. PCACH is working in partnership with the Opioid Task Force to ensure a collaborative and coordinated approach to reducing opioid use and overdoses.

PCACH's strategy is to identify the settings where people who use prescription opioids and heroin are engaged in services, then transform the experience they have within and across those settings by building upon the effective elements that are already in place and spreading them across the region. These settings include but are not limited to healthcare delivery; we will also work across community-based social services, the public safety sector, emergency services, and other sectors.

In addition to improving care within key settings, PCACH will also improve connections between those settings. We will work to create a coherent experience for our priority populations across disparate settings such as primary care and behavioral health clinics, hospital EDs, emergency response systems, jails, and social services agencies; one where the service providers in each of those settings have the tools and supports they need to work together in service to a shared vision and common goal.

PCACH's multi-faceted Opioid Project will support sustainable health system transformation for the target population by taking a systems approach to health system improvement via community, provider, and payer engagement. PCACH has been the catalyst to align multiple sectors with project strategies and tactics. Provider leadership and staff will actively engage with quality improvement efforts, and the expected outcomes will inspire all actors to sustain the myriad number of health care and allied system changes.

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[76] Medicaid claims, HCA Medicaid Transformation RHNI Starter Kit.

[77] Ibid.

[78] 2015 Drug User Survey.

Coordinated and Not Duplicative

To ensure coordination and avoid duplication, PCACH convened an Opioid Workgroup comprising multiple and diverse partners engaged in opioid-related work throughout the county. These include hospital systems, behavioral health providers, community-based organizations, representatives from county government, community health workers, managed care organizations (MCOs) and the criminal justice system. Working together, members of the workgroup crafted PCACH's approach to leverage existing efforts and expertise, fill gaps, avoid duplication, and target areas that require additional focus and resources. PCACH will continue to convene this Opioid Workgroup and partnering providers on a regular basis to ensure we are not duplicating existing efforts and that PCACH's work complements and enhances existing initiatives to address the opioid crisis.

To deepen our understanding of work underway and needs in the community, PCACH conducted a survey of partners, which included questions about opioid-related efforts, successes, obstacles, and possible solutions. We also conducted partner interviews. These meetings, discussions and surveys informed our strategies.

PCACH will continue to collaborate closely with the Pierce County Opioid Task Force, the Overdose Action Team established under SAMHSA's WA-Prescription Drug Overdose Prevention Grant, and the Hub and Spoke Program funded by the State Targeted Response Grant (STR). This will ensure alignment with other efforts in the region and broader engagement with State and local officials, legislators, judges, and law enforcement as well as with health and social service sectors. We have created intentional overlap in the membership of these groups so that we share information on a regular basis and avoid duplication as we develop a regional opioid work plan.

Anticipated Scope

PCACH proposes a multi-sector, multi-pronged approach to address the opioid crisis in our county that aligns with and advances goals and strategies outlined in the Governor's Executive Order, the 2016 Washington State Interagency Working Plan, and the Bree Collaborative. The approach also aligns with PCACH's system-level project portfolio and supports the Collaborative Care Model for whole-person health delivered wherever an individual seeks care.

Anticipated Target Population

The preliminary target population was selected based on recommendation from the Data & Learning Team: Medicaid beneficiaries who use opioids, particularly those with Opioid Use Disorder (OUD) who are not receiving medication assisted therapy (MAT). In each of the four categories of focus, PCACH will target the following groups:

- *Prevention:* Approximately 180,000 Medicaid beneficiaries receiving care through our partnering providers will receive broad prevention efforts, such as education and prescribing guidelines. Within that group, we will focus on people at risk of transitioning from appropriate use of opioids to chronic use, including the roughly 34,000 Medicaid enrollees with an opioid prescription.
- *Treatment*: Approximately 6,500 Medicaid beneficiaries with OUD.
- *Overdose Prevention:* Medicaid beneficiaries with an opioid prescription who are evaluated for a naloxone co-prescription, including approximately 6,870 Medicaid beneficiaries who have high-

dose prescriptions, and 6,890 chronic opioid users; and the approximately 2,812 people who inject heroin and do not have ready access to treatment or are not ready for recovery.

o *Recovery:* Medicaid beneficiaries in recovery, with a focus on those at risk for relapse, including the roughly 500 beneficiaries who receive MAT with buprenorphine, 1,075 who receive MAT with methadone, and those who have recently completed inpatient treatment.

Involvement of Partnering Providers

Since its inception, PCACH has convened and worked closely with Medicaid providers and other stakeholders from the medical and social services system. To design the Opioid Project, PCACH chartered the PCACH Opioid Workgroup in June 2017. The workgroup includes representatives from behavioral health organizations, substance use disorder providers, health systems, MCOs, community-based organizations, homeless shelters, community health workers, and the criminal justice system. Organizations that have participated include Pierce County Health and Human Services, Pierce County Council, Tacoma Recovery Café, Puyallup Police Department, Pierce County Sheriff's Department, Fire and Rescue, WA State Department of Health, Korean Women's Association, Molina Health Care, Metropolitan Development Council, Pierce County Probation, Northwest Integrated Health (Hub and Spoke), MultiCare, Northwest Physicians Network, Prosperity Wellness Center, Point Defiance AIDS Project – Tacoma Needle Exchange, Tacoma Pierce County Health Department, Planned Parenthood, CHI Franciscan Health, Catholic Community Services – Nativity House, Community Health Care (CHC), Crisis Clinic, Sea Mar Health Centers, and Pierce County Prosecutor's Office.

Organizations participating in the Opioid Workgroup reflect the broad range of sectors and organizations working with populations using opioids in Pierce County. This participation is critical to the project's goals to advance a community-wide and health equity-based approach to the opioid crisis that focuses on prevention, identifying and linking individuals to treatment, preventing overdose, and supporting long-term recovery.

Addressing Opioid as a crisis has four categories of focus: Prevention, Treatment, Overdose Prevention, and Recovery – this reaches across sectors and systems and requires a broad group of stakeholders.

o Strategies range from community education to changes in clinical workflows, and partners have a role to play at each step.
o Opioid stigma = community organizations, such as needle exchange or homeless services providers, will be crucial partners to build trust with the target population and connect them to services.
o Prevention of opioid addiction and expanding access to treatment will require changes to clinical practice for health system partners, including primary care providers, Behavioral Health providers, dentists, hospitals, ED providers so it is vital for PCACH to engage these providers in all stages of the work, etc.

Consideration on Level of Impact

Relying on data, recommendations from the Data & Learning Team, and a broad representation of stakeholders, PCACH looked at opportunities and gaps across the county to identify key target populations. In reviewing the data and prioritizing strategies, the Opioid Workgroup used a decision-making tool (see attachment 114) that considers the level of impact, specifically the number of Medicaid beneficiaries impacted by the strategy under consideration. Preliminary Workgroup conversations regarding subgroups and geographic areas of interest resulted in a commitment to ensuring the project

meets beneficiaries "where they are" to deliver appropriate services and maximize impact. As we continue to plan, the group will focus on rural areas of the region with reduced access to MAT, naloxone and syringe exchange services; age categories including 14 to15-year-olds and 20 to 39-year-olds, people with "rising risk" who may transition from appropriate to chronic opioid use, and those with co-occurring OUD and chronic disease (including Hepatitis C).

Health Equity

Stigma associated with opioid use disorder is considerable and reduces access to care, especially for injectors who may also be homeless. PCACH is acutely aware of this inequity and intends to use the Science of Improvement to ensure we address stigma and trauma informed care in all settings.

Health equity has been a foundational element in all matters of project design for PCACH. To ensure that individuals facing the greatest health disparities inform the community needs assessment and improvement opportunities, PCACH has focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of Pierce County Medicaid members. Because of this broad community engagement, diverse participation has been achieved for all PCACH councils and workgroups, including but not limited to: The Regional Health Improvement Planning Council, the Community Voice Council, the Provider Integration Panel, the Opioid Workgroup and the Care Coordination Advisory Group. These representatives have directly informed discussions and decisions regarding project selection, target populations, PCACH Transformation Rules of Engagement.

PCACH's Community Pathways Hub is expected to be an additional thread across all demonstration projects that contributes to the pursuit of health equity. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, community care coordination model will deepen beneficiaries' access to culturally and linguistically responsive care. When PCACH created its Request for Proposals (RFP) for Care Coordination Agencies (CCAs), it required that these potential HUB partners demonstrate their commitment to health equity. Furthermore, the PCACH invited Community Voice Council members to provide feedback on the draft RFP and to participate on the RFP review team to ensure that broad community perspective informed the CCA decision-making process. As a result, the four CCAs that have been chosen for the initial Pathways Hub pilot are trusted community partners that have deep experience in supporting the diverse cultural, linguistic and geographical needs of Pierce County members.

As PCACH has made preliminary decisions regarding target populations for its demonstration projects, intentional focus on the opportunity to advance health equity has been central. For example, one of the leading criteria applied when choosing target populations has been "need": Does the priority population disproportionately experience poor health outcomes? Are there subgroups within the population that experience disparities? Is there a gap in existing services that could effectively address these outcomes? By looking at disaggregated data for Pierce County and its Medicaid members, PCACH has been able to target their efforts to have the greatest impact on health equity.

PCACH is also working to deepen its impact on health equity through multiple, additional strategies. For example, PCACH will ensure that:

- Community training opportunities are available in multiple languages and across diverse cultural and geographical community sites
- A trauma-informed lens is applied to all the project designs (as informed through partnership

with the Tacoma/Pierce County Health Department which brings deep expertise in this area)
- The Board of Trustees receives intensive training on diversity, equity and inclusion
- An equity lens is applied to PCACH's policies/procedures/systems (e.g., hiring processes established that enhance diversity and inclusion in the ACH workplace)
- Cultural humility and trauma-informed care are incorporated as essential components of the Strategic Improvement Team's work
- Diverse community partners define the needed resources to strengthen Community Resiliency and will ensure that these needs are addressed through the PCACH's Community Resiliency Fund

Lasting Impacts and Overall Benefit

We hope to turn the tide of the opioid epidemic in our region. Through our work and the work of our partners, we want to prevent opioid addiction, ensure that opioid users have access to needed treatment and care, and prevent opioid overdoses and deaths. We are also aiming for culture change – we want to reduce the stigma surrounding opioid users, stigma that only serves as a barrier to needed care. We want to increase the capacity of our community to effectively serve and support this population through treatment and recovery. Through our work, PCACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and the commercial market. We expect that our deep collaboration with providers, Community Based Organizations and other stakeholders will lead to transformation and set a standard for the health landscape in our region and our State that offers whole-person integrated care for all those who seek it.

Key impacts from this project will be to number of people dying from opioid overdoses, to provide culturally appropriate treatment for individuals struggling with addiction, and to prevent new individuals from becoming addicted to opioids.

Strategy Impact and Benefits

- Implement opioid prescribing guidelines - Reductions new enrollees with opioid use disorder, and the number of individuals developing opioid addiction
- Increased access to medication assisted treatment, including access to low-barrier buprenorphine and methadone - Individuals will have more access to different treatment options
- Increase the capacity to the system to provide treatment to more individuals, in different settings
- Provide treatment options that meet people where they are at, with low barriers to engagement, reducing complexity for patients
- The goal is to see more individuals engaging in and successfully completing treatment

Increase access to naloxone - Fewer opioid overdose deaths

Utilize community-based care coordination - Provide supports to address social factors that impact health and opioid use, such as trauma, housing, transportation, etc.

- Help enrollees navigate complex systems of care
- Connect enrollees with on-going recovery supports

Project's lasting impacts and benefit to the region's overall Medicaid population

We hope to turn the tide of the opioid epidemic in our region. Through our work and the work of our partners, we want to prevent opioid addiction, ensure that opioid users have access to needed treatment and care, and prevent opioid overdoses and deaths. We are also aiming for culture change – we want to reduce the stigma surrounding opioid users, stigma that only serves as a barrier to needed care. We want to increase the capacity of our community to effectively serve and support this population through treatment and recovery. Through our work, PCACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and the commercial market. We expect that our deep collaboration with providers, Community Based Organizations and other stakeholders will lead to transformation and set a standard for the health landscape in our region and our State that offers whole-person integrated care for all those who seek it.

Partnering Providers

Serve a Significant Portion of Medicaid

Based on analysis of provider claims data provided by Health Care Authority, PCACH is working with partnering providers representing the highest Medicaid billers in each major setting (including primary care, behavioral health, inpatient and emergency departments). Across all settings, partnering providers engaged to date are responsible for 90 percent of Medicaid claims in the region. PCACH is also using the HCA provider claims data to follow up with and engage additional partnering providers that provide a significant portion of Medicaid services in the region and are not yet engaged in this work.

To develop the Opioid Project, PCACH convened and collaborated with partnering providers through the cross-sector Opioid Workgroup and the Provider Integration Panel (PIP). See attachment 115 and 112 for group rosters.). In addition, we conducted a Letter of Interest (LOI) process to gauge provider interest in participating with PCACH on the opioid project. In response, we received 38 LOIs representing primary care, behavioral health and other community-based social service organizations. See Table 7 for more details.

Letters of Interest Received (38)

- Organization Name
- Catholic Community Services
- Center for Dialog & Resolution
- Central Pierce Fire & Rescue
- CHI Franciscan Health
- Children's Home Society
- City of Tacoma Fire Department
- Community Health Care
- Comprehensive Life Resources
- Consejo Counseling & Referral Services
- Crisis Clinic
- East Pierce Fire & Rescue
- Emergency Food Network
- First5Fundamentals
- Gig Harbor Fire & Medic One

- Graham Fire & Rescue
- Greater Lakes Mental HealthCare
- Hope Sparks
- Korean Women's Association
- Leaders in Women's Health
- Lutheran Community Services Northwest
- Metropolitan Development Council
- MultiCare
- Northwest Integrated Health
- Northwest Physicians Network
- Orting Valley Fire & Rescue
- Pediatrics Northwest
- Perinatal Collaborative of Pierce County
- Pierce County Office of the County Executive
- Pioneer Human Services
- Planned Parenthood GNHI
- Point Defiance Aids Project/ NASEN
- Prosperity Wellness Center
- Samoan Nurses Organization (SNOW)
- Sea Mar Community Health Centers
- Sound Outreach
- Tacoma-Pierce County Health Department
- United Way of Pierce County
- West Pierce Fire & Rescue

Commitment to Serving Medicaid

By Spring 2018, PCACH will secure contracts with partnering providers and partners that will include a commitment to PCACH's "Transformation Rules of Engagement" and to serving the target Medicaid populations. PCACH's plan for ongoing monitoring and continuous improvement will also provide ongoing oversight of providers (by deploying the Strategic Improvement (SI) Team that will provide tools for reporting and ensuring processes are in place for check-ins and audit) that are serving Medicaid populations and implementing strategies that are working to reach the desired outcomes for the target Medicaid populations.

Process for Engagement

PCACH will continue to engage partnering providers critical to the Opioid Project's success through PCACH's various councils, workgroups, and relationships with external coalitions and taskforces throughout the region. New workgroups made up of subject matter experts from partnering agencies will be convened in the first quarter of 2018. These groups will address workforce development, value-based payment, population health management and will work closely with the Regional Health Improvement Plan (RHIP) Council and Provider Integration Panel (PIP) to operationalize PCACH's portfolio of projects.

PCACH will continue to collaborate closely with the Pierce County Opioid Task Force, the Overdose

Action Team established under SAMHSA's WA-Prescription Drug Overdose Prevention Grant, and the Hub and Spoke Program funded by the State's Targeted Response Grant. This will ensure alignment with other efforts in the region and broader engagement with State and local officials, legislators, judges, and law enforcement as well as with health and social service sectors. We have established overlap in the membership of these groups to ensure information sharing and to avoid duplication as we develop a regional opioid work plan. We will continue to expand our outreach to additional providers and social service organizations where we identify gaps in serving the target population.

MCOs Expertise

PCACH has been working with MCOs in multiple ways to leverage their expertise, identify areas of alignment, and ensure there is no duplication. MCOs have been active participants across all PCACH councils and workgroups, including but not limited to: The Board of Trustees, the Waiver & Investments Committee, the Regional Health Improvement Planning (RHIP) Council, Community Voice Council, the Data and Learning Team, the Provider Integration Panel, the Opioid Workgroup and the Care Coordination Advisory Workgroup. Through these roles, MCOs have directly informed discussions and decisions pertaining to project selection, target populations, and PCACH's Transformation Rules of Engagement for partnering providers.

Pierce has engaged in targeted conversations regarding MCO's efforts to track outcomes, engage providers, and develop strategies related to opioid use. Several MCOs have shared high level data on regional opioid prescribing patterns and efforts to educate providers on opioid prescribing guidelines. MCO Medical Directors have presented at Opioid Workgroup meetings and have been deeply engaged in conversations to identify strategies and approaches.

In addition to this intentional and broad engagement, PCACH has met with each MCO over the past few months to explore the following key questions:

- What is the makeup of your member population?

- What key population health strategies are already underway?

- How can PCACH complement existing MCO efforts in the area of provider support?

- What opportunities for alignment exist with regards to measures, key metrics, and quality improvement efforts?

- How can PCACH support the rollout of provider Value Based Payment contracts?

- How are Primary Care Provider assignments and empanelment determined?

- What is needed to ensure the sustainability of demonstration projects?

As a result of these conversations, PCACH and MCOs have identified the following opportunities across each project area for deepened and coordinated work: 1) Assessment and support to expand provider readiness for VBP contracts, 2) Optimization of data sharing to inform monitoring and continuous quality improvement, 3) Provider support regarding utilization of data to inform quality improvement efforts, 4) Provider support regarding adoption of effective strategies to improve patient engagement, and 5) Coordination between the Pathways Community Hub and health home models to ensure that members needs are being met, duplication is avoided, and value-based payment methodologies are advanced. Through ongoing coordination and participation on PCACH councils and workgroups, MCOs

will actively inform the final planning, implementation and sustainability phases for all demonstration projects. In addition, the PCACH Strategic Improvement Team—currently under development—will be a key point of PCACH/MCO coordination regarding continuous quality improvement and assurance of the necessary HIT/HIE resources to advance practice and community-level transformation.

Regional Assets

PCACH will make the following regional investments to support the portfolio of projects, inclusive of the Opioid Project:
- ACH Staff & Share Learning Structure
- Pathways Community HUB
- Data Analytics Platform
- Population Health Management System
- HIT/HIE/EHR strategy to coordinate care (primary care, behavioral health, SUD, ED, EMS, CBOs, etc.)
- Strategic Improvement Team (Improvement Advisors – clinical and non-clinical)
- Tools and technical assistance support:
  - Technical assistance to implement the prescribing guidelines will be assessed from sources such as the Practice Transformation Hub, Bree Collaborative, and "6 Building Blocks for Implementing Prescribing Guidelines"
  - MAT training and waiver is currently provided locally by Dr. Khan, Northwest Integrated Health. PCACH will work with him to scale and spread this training to all interested providers
  - Science of Improvement
  - Facilitation, Coaching, Training, Consultation
  - Project Management
  - Accountability
  - Performance Technology
  - Change Management
  - Population Health Management (HIT/HIE)
  - Workforce Development strategies
  - Contracting / Billing / VBP
  - Communication Strategies
  - "Care of the Provider", "Joy in Work"
  - Policies and Procedures
  - Transformation Rules of Engagement Deployment
  - Self-monitoring and Reporting
  - Pay for Reporting Tools and Capabilities (worksheet and electronic reporting questionnaire/survey with metrics and definitions)
  - De-escalation Training and Techniques; recovery-oriented care
  - Awareness and Sensitivity Education and Training (cultural, equity, behavioral health)

Through partner interviews and inventories, we understand that our partners also bring significant assets to this specific project area, including the following:

Prevention: MultiCare, CHI Franciscan, Sea Mar, Community Health Care, and Northwest Integrated Health have been leaders in prevention and altering prescribing practices. Their internal provider champions have taken steps toward implementing prescribing guidelines. PCACH will work closely with these organizations to learn, scale and spread success, and provide

technical assistance where needed.

Treatment: Hub and Spoke grantee Northwest Integrated Health, and regional spoke agencies (Greater Lakes Mental Health, Olalla Recovery Centers, Franciscan St. Clare Hospital, Puyallup Tribal Health Authority, Community Health Centers, Tacoma Needle Exchange, Pierce County Alliance/Pierce County Drug Court, Nisqually Tribal Health) have integrated behavioral health and primary care services and are imbedding navigators within CBOs to increase access to MAT. The Tacoma-Pierce County Health Department's methadone clinic has a primary care provider on staff, is providing integrated care, and is referring to the Hub and Spoke to reduce waiting lists for appropriate treatment. Our partners Molina and Sea Mar have been champions of telehealth and we will build on their expertise.

Overdose prevention: Our partner Point Defiance AIDS Project (PDAP) has significant experience with needle exchange, overdose prevention, and technical assistance to establish standing orders to distribute naloxone. PDAP will lend their expertise to our project, along with the Center for Opioid Safety and Education (COSE) and DSHS through a five-year SAMHSA grant received in 2016.

Recovery: Our recovery initiative will build on existing resources and subject matter expertise from the Foundation for Healthy Generations, the Pierce County Community Health Worker Collaborative, Samoan Nursing Organization of Washington (SNOW), Recovery Café, Northwest Integrated Health, Metropolitan Development Council, Prosperity, Pioneer Health Centers, and Pierce County Alliance. We will work to build care coordination resources within these agencies to improve access to recovery supports, with a focus on providing culturally appropriate resources.

Anticipated Challenges or Barriers

General challenges to the success of this project include information exchange, workforce, provider training, and related startup costs. According to partner inventories, the following areas arose as the main challenges to improving outcomes and lowering cost for treating the opioid target population:
- Workforce
  - Service area gaps
  - Addiction medicine education for primary care providers
  - Challenge of providers embracing new skills
- IT integration
- Quality Improvement
  - Training/technical assistance for implementation
  - Prescribing guidelines/workflows/clinical pathways/policies procedures/standing orders and protocols
  - Addiction medicine education for primary care providers
  - SBIRT will increase time of preventative visits
  - Clinical supervision needed in community-based settings
  - Case management for office-based opioid treatment programs
  - Screening tools, need help creating partnerships
- Community Care
  - Need for community-wide referral system

- o Community Education
    - Stigma against people with Opioid Use Disorder and OUD treatment prevents patients from accessing care and may prevent providers from implementing evidence-based practices
- o Cost Factors
    - Cost of naloxone
    - Reimbursement rates in general and for certain services delivered in specific settings (i.e. nurse care managers are not reimbursed for services delivered in community-based settings).

Mitigating Risks and Barriers

Three mechanisms will mitigate these risks and overcome barriers: Domain I investments in HIT and workforce (related to information exchange and workforce); the "Transformation Rules of Engagement" for partnering providers for the Bi-Directional Care Project, and the technical assistance and support that will be offered by the Strategic Improvement (SI) Team (related to training).

HIT/HIE Investments

The Pathways HUB will provide connectivity of information between the clinic and the community; improve equity and access by focusing on the social determinants of health; address workforce challenges and allow clinicians to work at the top of their license; and provide a community-wide referral source. The Hub will employ an internal clinician that will assist care coordinators in working with complex patients, which will benefit the effort to better serve individuals with OUD.

Workforce Investments

PCACH plans to leverage the work of the Workforce Development Council on a high-level assessment of workforce capacity and gaps in Pierce County to develop a targeted approach to workforce needs for bi-directional care. Preliminarily, PCACH is considering the following solutions in this area:

- Telehealth and telepsychology as potential solutions to workforce gaps in urban and rural areas of the region
- Working with the Puyallup Tribe to explore ways to assist, encourage, and incentivize members of their clinical residency program to be retained within the region's workforce.
- PCACH leadership is also exploring solutions to recently identified licensure barriers for the State's behavioral health residential treatment programs.

"Transformation Rules of Engagement"

Starting in mid-2017, the Provider Integration Panel (PIP) began developing White Papers on integration and primary care medical home. Through this work, the PIP developed the Transformation Rules of Engagement as they advanced Pierce County's Transformation of Care and Service Delivery Settings model. At the outset, the Transformation Rules of Engagement defines the expectations for partnering providers and partners in the region that are participating and bi-directional integration. The Transformation Rules of Engagement outlines partnering provider and partner expectations in terms of design, practice change, tools and validated screening instruments, performance management, equity and inclusion, reporting requirements and other requirements for MTP. The goal of developing the "Transformation Rules of Engagement" early was to gain consensus, establish the expectations, and develop a regional model while enabling the providers and partnering organizations the opportunity to plan for practice and organizational change and upcoming delivery system change.
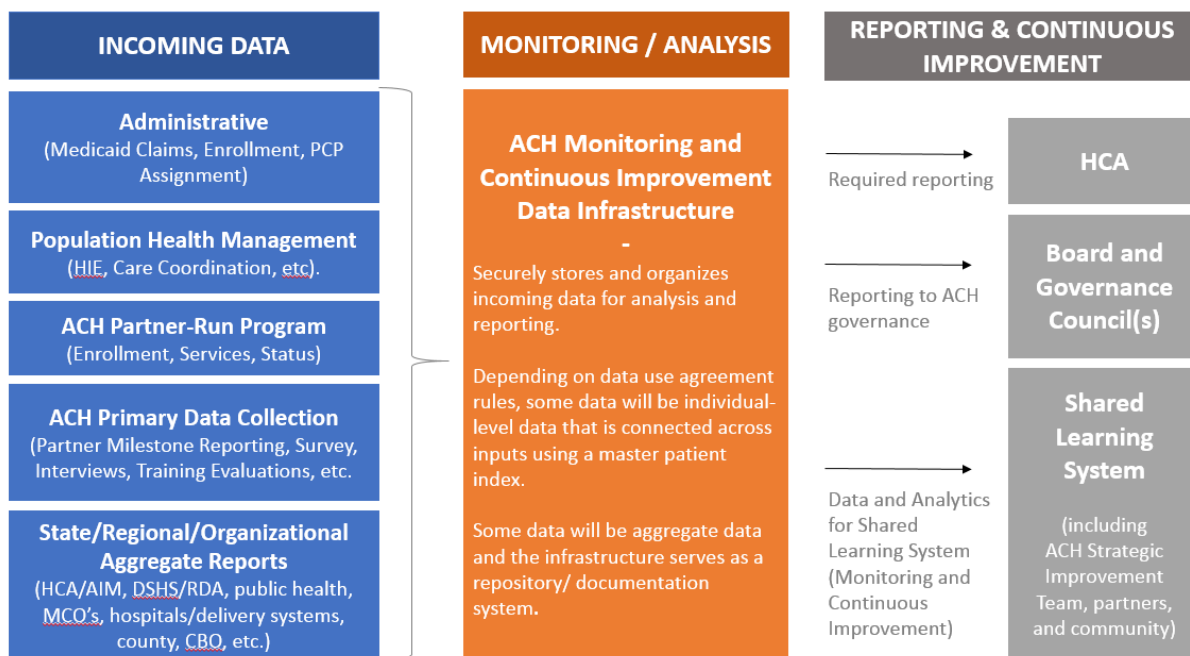
Strategic Improvement (SI) Team

The Strategic Improvement (SI) Team is complementary in nature to the PIP in that it will be responsible for supporting the success of the project by providing the necessary trainings and support to engaged providers to ensure their successful implementation of the project. The SI Team will do this by arranging trainings, establishing learning collaboratives and other opportunities for shared learning across the project's partnering providers. To support the opioid project, the SI Team will provide: technical assistance (TA) to implement prescribing guidelines; waiver training to prescribe MAT; assistance with policies, procedures, workflows and clinical pathways and; training to identify OUD and link patients to treatment. The SI team also will provide support for value-based payment and technical assistance regarding contracting. As it structures training and TA, the SI Team will consider elements of the "Six Building Blocks for Implementing the Prescribing Guidelines," study evidence-based recommendations for practice transformation from the Bree Collaborative, and seek to leverage and replicate technical assistance available through the DOH Practice Transformation Hub.

PCACH also is coordinating with Seattle King County ACH to explore technical assistance cost sharing and to ensure alignment so that providers and MCOs have common requirements across regions.

Monitoring Implementation Progress

PCACH is building a monitoring and continuous improvement infrastructure and process to support the Transformation of Care and Service Delivery Settings through MTP and a community-wide system of care working collectively to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, the PCACH Strategic Improvement Team, and reporting at multiple levels including providers, community, PCACH governance, and HCA reports. (See Figure 21.)

Figure 23. Process for Monitoring and Continuous Improvement

INCOMING DATA	MONITORING / ANALYSIS	REPORTING & CONTINUOUS IMPROVEMENT
Administrative (Medicaid Claims, Enrollment, PCP Assignment)	**ACH Monitoring and Continuous Improvement Data Infrastructure** - Securely stores and organizes incoming data for analysis and reporting.	Required reporting → **HCA**
Population Health Management (HIE, Care Coordination, etc).	Depending on data use agreement rules, some data will be individual-level data that is connected across inputs using a master patient index.	Reporting to ACH governance → **Board and Governance Council(s)**
ACH Partner-Run Program (Enrollment, Services, Status)	Some data will be aggregate data and the infrastructure serves as a repository/ documentation system.	Data and Analytics for Shared Learning System (Monitoring and Continuous Improvement) → **Shared Learning System** (including ACH Strategic Improvement Team, partners, and community)
ACH Primary Data Collection (Partner Milestone Reporting, Survey, Interviews, Training Evaluations, etc.		
State/Regional/Organizational Aggregate Reports (HCA/AIM, DSHS/RDA, public health, MCO's, hospitals/delivery systems, county, CBO, etc.)		

The data infrastructure to support monitoring and continuous improvement will complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon "point of care" population health management system inputs needed for projects. Among the incoming data in Figure 23 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2)key data identified by the Opioid Workgroup and the ACH Strategic Improvement Team needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/ sustainability, and spread.

PCACH has contracted with the Center for Outcomes Research & Education (CORE) at Providence Health & Services to design and run the monitoring system. The system will bridge all partner organizations by collecting, storing, aggregating, analyzing, and reporting key data elements from each partner/data source, to serve as a hub for all quality and monitoring activities.

The PCACH monitoring and continuous improvement system will incorporate key process measures and milestones for project implementation, as shown in Figure 1. For example, the number of providers trained to implement the opioid prescribing guidelines or trained and waivered to prescribe MAT. Adjustments to implementation timelines will be triaged through this system and with course corrections wherever possible. Progress and status of timelines will be monitored by PCACH with clear lines of communication and accountability between partnering providers, PCACH staff, CORE, and PCACH governance body.

If timelines still cannot be met the PCACH will communicate a plan back to the State regarding reasons why timelines weren't met. A plan for adapting the timeline and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Monitoring Continuous Improvement

Through its Strategic Improvement Team, PCACH will create and run a unified system of rapid cycle

feedback and quality improvement across all the organizational partners and to ensure the successful progress toward milestones and outcomes and reporting is done in a timely and quality manner. This system will incorporate a comprehensive shared learning system that follows the best practice of a "plan, do, study, act" (PDSA) continuous quality improvement process.

PCACH has developed a Strategic Improvement infrastructure that consists of improvement advisor that provide support for providers – across all projects – to achieve continuous improvement. The following content on the key general supports will apply across the board for projects, but project-specific supports like the exact trainings, tools, and technical assistance will vary by project and provider and will unfold as these teams undergo a process for developing specifics. The following content outlines the general supports and approach, the process for developing specifics (including some example specifics), and additional thinking and work done to date related to this topic.

Key general supports for partnering providers to achieve continuous improvement include:

1) PCACH-funded Data Analytics, Performance Monitoring, and Quality Improvement Processes and Programming. The following are examples of key general supports:

- Strategic advisement and technical assistance on defining project metrics
- Strategic advisement on how quality and other metrics are measured and related technical assistance to improve reporting and documentation process
- Strategic advisement on how to improve quality outcomes and tools for achieving those outcomes
- PCACH-wide performance monitoring dashboards
- Where possible, data analysis of performance to understand what's driving performance rates and forecasting related to hitting targets
- Ensuring participating providers and partners have pay for reporting tools and capabilities in place
- Assessments on connectivity with various partners data including administrative data, MCOs, CCS (Pathways) platform and Chronic Disease, etc. for data and pull together (with CORE's oversight) for regional dashboard
- Ensuring shared learning system is accelerating implementation, spread, and scale-up of innovative approaches to improving health outcomes

  In addition to the Data Analytics, performance Monitoring, and Quality and Continuous Improvement, PCACH is funding Strategic Improvement Team consisting of Improvement Advisors and Continuous Quality Improvement workgroup. These resources will leverage the data provided to guide their efforts in providing technical assistance, practice coaching, and trainings to the providers.

Strategic advisement and technical assistance on data collection best practice and methods for tracking metrics and ensuring provider proficiency at reporting on required PCACH and MTP level reporting requirements (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and regularly report on a monthly, quarterly and annual basis

The system will be informed by key planning inputs that better position PCACH to invest in and provide key supports to providers and organizations, ensuring they are meeting the goals of each phase. It will be designed with multiple-stakeholder input and clear lines of accountability of key roles/people and PCACH governance groups. This system will incorporate tools for data collection and monitoring that are dynamic, flexible, and calibrated to effectively meet the needs for each evolving stage of the

Demonstration in each project area.

Identification for Initiatives or Strategies Not Working

The comprehensive shared learning system and PDSA continuous improvement process will support PCACH and our partners to rapidly identify opportunities for course correction and adjust strategies to meet our targeted outcomes.

PCACH-funded Strategic Improvement Team (SI Team) and Quality & Continuous Improvement Workgroup (QCI) will provide support for rapid cycle feedback and quality improvement (Improvement Framework and Science of Improvement model, see Attachment X and X provided in our original project plan submission) the following examples of key general supports:

- The Strategic Improvement Team will work together with our provider practices and partners to ensure that all improvement efforts include, IHI's Science of Improvement steps:
    - A clear, measurable aim (focused on MTP projects are at the center - i.e. integration, opioid, chronic disease, transitional care, diversions)
    - A measurement framework in support of reaching the aim
    - A clear description of the ideas (content) and how these ideas are expected to impact the results (the causal pathway from changes to desired outcomes)
    - A clear description of the execution strategy (what will be done to ensure reliable adoption of the content?)
    - Dedication to rapid testing (PDSA cycles), prediction, and learning from tests
    - Understanding, describing, and visualizing systems (e.g., using a process map or value stream map)
    - Learning from variation and heterogeneity:
        - Use of time-ordered data to detect special cause and improvement
        - Understanding why results differ by location (ward, organization, etc.)
    - Application of behavioral and social sciences
    - Application of pay for reporting tools for improvement and waiver project reporting to enable payment and progress toward improvement
    - Building science-based improvement capability at provider, team, clinic-wide and system level
    - Ensuring quality improvement knowledge and skills are provided to participating providers and health care workforce
    - Ensuring the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
    - Providing a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results

• The Quality & Continuous Improvement Workgroup will be an external team made up of quality and clinical improvement individuals in regional partnering organizations that support the quality improvement activities associated with PCACH's transformation efforts.

- QCI Workgroup comprised of Quality and Clinical Improvement level participants from participating providers/partners, staffed by Director of Strategic Improvement;
- Establishment the Systems and Capacity Building Fund to provide resources for quality improvement education, training, technical assistance, education, practice improvement

and support for participating providers; and

- o Adoption of Science of Improvement methodology that allow for new and innovative strategies.

Project-Specific Supports: The above content describes the general approach to supporting providers for continuous improvement. Due to the timing of writing this project plan and PCACH progress on hiring and staffing these key roles to facilitate deeper development of specifics, PCACH has not had staff in place long enough to articulate all the project-specific measures, trainings, tools, etc. that they will provide, though PCACH was proactive at assessing each provider's specific needs, there has not been time to develop a resulting tailored QA plan.

That being said, PCACH can articulate the process by which they will develop more specific supports.

This process includes:

- Phase I Partner Inventory (COMPLETE) - PCACH has completed and reviewed a starting inventory of partnering provider interests, needs, and goals as it relates to the Demonstration project areas. This Phase I Partner Inventory was a 12-page document, exploring individual organization's interest and barriers to participation in MTP. The inventory was sent out in September 2017 to more than 70 different types of organizations, such as clinical providers, hospital systems, behavioral health providers, EMS, and community-based organizations. PCACH received over 30 responses, with approximately 10 from clinical providers and hospital systems, 10 from behavioral health providers and 10 from community-based organizations. This information has provided a starting point for the SIT to plan specific TA, training and education.
- Phase I Partner / Provider Guided Discussions for Portfolio Development (COMPLETE) – PCACH followed up with key providers to have more in-depth discussion based on inventory responses.
- Develop and Adopt Rules of Engagement (COMPLETE) - PCACH has developed and adopted Rules of Engagement that outline expectations of providers under the Demonstration. These rules will provide clarity on specifics so that the SI Team can develop a corresponding plan for support and identifying risks.
- Phase II Partner Inventory/Assessment (Upcoming) – PCACH will conduct a formal "current state assessment" across all projects that will provide an up-to-date inventory of current state and barriers/haps to achieving future state expectations (rules of engagement) and additional conversations for the implementation design phase.
- Implementation Design Phase (Under development and deployment upcoming) – PCACH will continue to engage providers during the implementation design phase. This engagement will involve developing out a plan for quality improvement and technical assistance (a strategic improvement toolkit) needed from providers to be successful in achieve milestones and outcomes by project.

Example 1:

- Partnering Provider A identifies in their inventory that they lack the technical systems needed to fulfill required reporting for a project area.
- PCACH has a follow up guided discussion with the partnering provider to understand why these systems are not in place – documenting the barriers and supports needed. This information goes into PCACH's planning process, of all provider barriers and supports that feed into PCACH's Strategic Improvement Team's

- PCACH developed out and governance structure and then the Board adopted the Rules of Engagement so that there are clear required expectations of that provider to fulfill the reporting while simultaneously co-developing with the provider- in planning and further development the implementation design phase, a plan for providing assistance to build up the providers capacity to fulfill reporting requirements. This could include strategic advisement and TA on tracking the right inputs and extracting reports from their existing systems.

Real-Time Data / Day-to-day Performance

To date PCACH has explored options for data inputs for monitoring and quality improvement including proxy measures for performance monitoring and QI when ideal inputs may be unavailable. PCACH's goal is to identify data sources and/or processes that will help PCACH track provider/partner progress and/or activities that will lead to improvement for the pay for performance measures.

Problems – Access to Timely Data/Reports for Performance Monitoring and Analysis many of PCACH pay for performance measures will be subject to claims lag and other processes that will prevent PCACH from being able to monitor performance progress on these metrics in a timely manner. PCACH will also need access to data or reports on the metrics that will allow them to analyze the data to do things like identify disparities by population (are there specific populations that have lower rates of well child visits?), geography (are there differences in rural or urban communities on well child visits?), or provider (are there differences by clinic in well child visit rates?)…and the interaction of these factors that could lead to identifying more complex issues.

Example: a key input for monitoring and QI could be Administrative Data on Medicaid Population through Medicaid Claims / Enrollment – the data source for the majority of the pay for performance metrics. Though this information is not real-time, it could be used for metrics forecasting. Providence CORE has a metrics and forecasting team that specializes in forecasting metric rates, though again, as PCACH's data analytics vendor, PCACH has been told that they cannot put agreements together to give their data analytics vendors access to these data for monitoring and QI.

Possible Solutions – Develop Proxy Measures and Data Sources: Despite barriers to access to data, PCACH will continue to work through the metrics and identify data sources and processes that could be explored as proxy sources (e.g. which health care settings are key to this metric? which project area implementation steps or program workflows and data that could have QIP metrics added to them?).

Examples:

1. ED Visits: Could a region reliably monitor ED visits through EDIE data as a proxy data source for the P4P ED measures? I mentioned the challenge of trying to translate EDIE data to a proper rate per member or rate per 1,000-member months would take some thinking. Since most of the performance measures have layers of criteria for inclusion and exclusion (especially those that rely on coverage or other utilization in claims) that a proxy data source may lack, there will be some instances where this will be more worthwhile/feasible than others. Continuing on this example, would we be able to explore EDIE data for patterns by population, geography, and/or emergency department? And for an ACH that might be interested in a monitoring approach that has a public surveillance lens to it – that ACH might leverage data like these to do more real-time community wide monitoring of emergency department use trends.
2. Clinical Processes: identify clinical processes that could be adapted and tracked to ensure that we

see change within clinics that ought to lead to performance improvement. This falls pretty squarely into the world of QI.

3. Measures of Care Coordination: I mentioned that measures of care coordination will often have other systems where activities are tracked that could serve as process data. For example – in Oregon there was a program that the county ran to follow up with people who were hospitalized for mental illness. It was the goal of the program to do this within 7 days (which was the CCO's P4P measure). To run this program, they had real-time data of hospital admissions and tracked their program team's follow up activities, including if they got people into outpatient care. This kind of process/program data could be a good monitoring source for the related HEDIS measure 7-day Follow Up After Hospitalization for Mental illness.

4. EHR Data – The SI Team will work directly with providers so that they themselves are being trained to use their own data to monitor their day to day performance. The ACH is hopeful that this could be the source of performance monitoring at a provider level but will process with cautious as this solution provides an additional upfront burden on providers, though would provide long-term use for providers.

5. MCO Contract Measures: MCO's already monitor provider performance on many P4P measures. How do we best leverage this work? To date, MCO's have expressed PCACH that this option is not preferable.

Phase II Partner Inventory/Assessment (Upcoming) – PCACH will conduct a formal "current state assessment" across all projects that will provide an up-to-date inventory of current state and

Project Sustainability

PCACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation. PCACH is facilitating new linkages between providers and CBOs with the expectation that these partnerships will become part of the infrastructure and an accepted way of doing business. Information from our partners suggests that while providers have begun to think about how to foster bi-directional partnerships, necessary linkages to non-traditional or community-based partners are lacking. PCACH will help establish firm clinical community linkages with incentive dollars and shared accountability to ensure seamless coordination of whole-person health and support for the full continuum of care. This approach will ultimately lead to increased access to MAT, peer recovery supports, care coordination, and harm reduction services.

In addition, PCACH is working with providers to move from volume to value in order to transform practices. To do this, PCACH and its Strategic Improvement (SI) Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers to help them meet established success measures and outcomes. Implementing the prescribing guidelines goes beyond addressing work flow, policies and procedures, and the PDMP. Practices may also need assistance with a culture shift that includes addiction education, reversing stigma, and integrating care coordination.

PCACH's Community Resiliency Fund is a key sustainability strategy. During the Demonstration, PCACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resiliency through social determinant investments and key policies and system changes for overall population health. The Community Resiliency Fund will deepen and strengthen existing investments, as well as provide a model

for future investments—one that builds off PCACH's infrastructure and vision and is adaptive to the changing landscape. We know that the opioid use crisis is intimately tied to economic inequality and a lack of affordable housing. Our solution must include investments to improve these social factors.

Impact Beyond MTP

PCACH is approaching the opioid crisis as an intertwined system change required in the overall transformation across numerous care and service delivery settings. Our community-driven strategy for shared learning and action has and will continue to include core principles, including participatory decision-making, developing and maintaining capacity, and surfacing and amplifying community power to produce lasting change. We anticipate that, under these conditions and principles, our efforts will transform health and allied systems well beyond the demonstration. Through our work, PCACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and the commercial market. We expect that our collaboration with providers, CBOs and other stakeholders will set a standard for the health landscape in our region and our State.

3D: Chronic Disease Prevention and Control

Rational for Selection and Expected Outcomes

PCACH has identified Chronic Disease Prevention and Control as a priority for the region and will focus on sustaining implementation of the evidence-based Wagner's Chronic Care Model (CCM) across diverse care settings. CCM will serve as a key strategy to ensure integration of health system and community-based approaches to improve health outcomes, with special focus on Pierce County's Medicaid beneficiaries experiencing the greatest level of disease burden.

Pierce County Medicaid beneficiaries face a heavy burden of chronic disease and health disparities. As identified through the Regional Health Needs Inventory, 30,770 (16.1 percent) Pierce County Medicaid enrollees have one chronic condition and 21,293 (11.2 percent) have two or more. The rates for specific chronic diseases include: 17.6 percent of adults with a diagnosis of asthma or chronic obstructive pulmonary disease (COPD); 14.4 percent with a diagnosis of hypertension, 9 percent have a diagnosis of Type 2 Diabetes, 8.7 percent have cardiovascular disease, 2.8 percent have cardiomyopathy or congestive heart failure, and 2.5 percent have cancer.

Nearly 61,000 (about 28 percent) Medicaid members in Pierce County have been diagnosed with mental illness (MI) and more than 50,000 (about 27 percent) have been diagnosed with at least one chronic condition. Almost 22,000 have a diagnosis related to alcohol or substance use. More than 41,000 enrollees have co-occurring chronic conditions and behavioral health diagnoses and almost 18,000 have co-occurring Substance Use Disorder (SUD) and MI diagnoses. All of these rates are slightly higher than state average, making this project area a critical area of focus for Pierce county residents and providers.

Pierce County's high rates of chronic disease, MI, and SUD are even higher among specific populations, creating some marked disparities in chronic disease, MI, and SUD burden. Among whites, 25.3 percent have at least one chronic condition, compared with 31.4 percent of Native Hawaiian/Pacific Islander enrollees, 29.7 percent of Asians, and 30 percent of Hispanics. Rates of SUD plus MI diagnoses are highest among American Indian/Alaskan Native (13.4 percent). More than 41,426 (21.7 percent) of enrollees have co-occurring chronic conditions and behavioral health diagnoses with American Indian/Alaskan Natives (32 percent) and whites (25.9 percent) having the highest rates. Although Native Hawaiian/Pacific Islander have high rates of diagnosis for at least one chronic condition, they did have the lowest rates (11.8 percent) of co-occurring chronic conditions and behavioral health diagnosis—an important difference to consider as some populations will be less likely to develop behavioral health issues or may go undiagnosed.

These statistics indicate that chronic disease management needs to be a key focus area for Pierce County. The higher-than-state-average rates of disease coupled with Pierce County's poor access/penetration of services for MI and SUD care as well as low rates of diabetes care prevention require that the region establish shared efforts and measurements to improve these outcomes. In addition to the data-driven decision to choose this project, through the RHNI process, diabetes was chosen as a community priority area. Prioritizing chronic disease management as a project allows for PCACH to respond to that community priority. We also believe that our efforts for integrating primary care with behavioral health care will be more successful when complemented with chronic disease management standards. There is alignment in the providers and shared resources needed to implement both projects and general benefit overall to managing chronic disease among populations with

behavioral health challenges.

This project choice was vetted through extensive community conversations, including twice-monthly meetings of PCACH's Provider Integration Panel (PIP) beginning last spring. We have involved hospital systems, physical care providers, behavioral health providers, substance abuse disorder providers, emergency services organizations, community-based organizations, representatives from county government, managed care organizations (MCOs) and the criminal justice system in these discussions. Since May 2017, PCACH leaders have also been meeting directly with individual providers and provider organizations to assess their capacity in chronic disease prevention and control, learn what services they are already providing or would like to provide, and identify what supports they are going to need for expansion. The CCM has been noted to dovetail perfectly with the Collaborative Care approach already underway in the region and presents an opportunity to deepen impact for Medicaid enrollees living with or at risk for chronic disease in Pierce County.

Through prioritization of the Chronic Care Model, PCACH will support sustainable health system transformation for the target populations in the following ways:

- Expand the necessary infrastructure to assess efficacy of current approaches, as well as identify additional needed capacity/resources across the Pierce County community
- Align chronic disease and prevention efforts across health system and community partners that allows for greater efficiency and deepened impact
- Extend intentional focus on specific subpopulations experiencing the greatest health disparities
- Build experience with the use of data, Health Information Exchange (HIE)/Healthcare Information Technology (HIT) resources and quality improvement (QI) tools across regional providers and organizations
- Deepen experience with Value-based Payment (VBP) contracting among providers and community-based organizations related to chronic disease prevention

With an intentional focus on these goals, the PCACH will transform systems of care to produce meaningful health improvements.

Coordinated and Not Duplicative

Throughout planning for the Chronic Disease Prevention and Control project, the PCACH worked to ensure coordination and avoid duplication through its broad engagement with a multitude of partners and community members. To gain a deeper understanding of work underway and the needs in the community, we surveyed our partners about their work in chronic disease and prevention to learn about the successes they have experienced, the obstacles they have faced and to discuss solutions for moving forward. We are also gathering information to ensure that we are not adding unnecessary layers to the work of providers and community-based organizations (CBOs), but rather are filling identified gaps. This included co-creating the PCACH's Transformation Rules of Engagement with many partners to ensure consistent guidelines across care settings, ensuring transformation of care versus supplanting of existing efforts. During the planning period, we will continue to routinely convene groups of providing partners on a regular basis to ensure we are not duplicating existing efforts and that PCACH's work complements and enhances existing initiatives to address chronic disease and prevention.

Anticipated Scope

PCACH's Chronic Disease Prevention and Control Project will be focused on implementation of Wagner's evidence-based, Chronic Care Model across care settings for a set of targeted populations. This project will be centered on the following drivers of change:

- Adoption of PCACH's Transformation Rules of Engagement ensuring consistent guidelines across regional partners;
- Implementation of chronic disease self-management (CDSM) interventions;
- Provision of support for effective complex care and disease management for targeted populations; and
- Utilization of Community Voice Council (CVC) & PIP to support interventions.

As participants in the Chronic Disease Prevention and Control project, prospective transformation partners must decide on 1) the target population(s) they will focus on, as well as 2) the change strategy they will implement from a list of the CCM elements, including:

1. Systems of care: promote effective improvement of strategies aimed at comprehensive system change, encourage open and systematic handling of errors, provide incentives based on quality of care, develop agreements that facilitate coordination of care across organizations
2. Self-management support: train providers and staff to help patients with self-management goals, use evidence-based, self-management tools, use group visits to support self-management, set and document self-management goals collaboratively with patients, follow-up and monitor self-management goals
3. Delivery system design: use planned interactions to support evidence-based care, ensure regular follow-up by care team, define roles and tasks of team members, provide clinical case management services for complex patients
4. Decision support: embed evidence-based guidelines into daily clinical practice, integrate specialty expertise in primary care, share evidence-based guidelines and information with patients
5. Clinical information systems: provide timely reminders for providers and patients for recommended care, identify relevant subpopulations for proactive care, facilitate individual patient care planning, share information with patients and providers to coordinate care, monitor performance of practice team
6. Community-based resources: encourage patients to participate in effective community programs for partnerships with community organizations to support and develop interventions that fill gaps in needed services

In addition to these CCM elements, each transformation partner can choose optional activities or community-based partnerships, such as implementation of the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, Centers for Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program, and/or partner with community paramedicine. Finally, all transformation partners will need to identify an HIT/HIE/ Electronic Health Records (EHR) strategy with support from the PCACH's chief information and technology officer to better coordinate community linkages and will also be required to participate in the PCACH's Pathways Community HUB.

One of the leading approaches that PCACH will undertake to advance the communities' work in chronic disease prevention and control is through the implementation of the PCACH's Strategic Improvement (SI) Team. PCACH is adhering to the principles of science of improvement, shared learning and the

building of improvement capabilities through our development of an SI Team that will ensure our regional work is driven by improvement science. The SI Team will coordinate with PCACH's chief information and technology officer to ensure population health strategies, including HIT/HIE, will support our providers throughout the spectrum of care and beyond the primary care setting.

Anticipated Target Population

PCACH has used a multi-phase process to identify target populations for the Chronic Disease Prevention and Control project. With the help of Providence Health & Services Center for Outcomes Research and Education (CORE) and the PCACH's Data and Learning Team (DLT), workgroup and council members were asked to identify populations according to need and potential for impact.

Because of these assessments and a deep look at regional data, a set of priority populations with multiple chronic care conditions were identified as the target populations for this project, including:
- Adults with diabetes (particularly Type 2)
- Children and adults with obesity
- Children and adults with asthma/chronic obstructive pulmonary disease (COPD)
- Adults with hypertension and cardiovascular disease

Partnering Providers Thus Far

Partnering providers have been deeply engaged in project development through extensive community meetings, participation in discussions and decision-making through PCACH workgroups and councils, and through direct outreach from PCACH leadership. Provider input is key to obtain an on-the-ground understanding of priorities, capacity, and needed resources. In addition, to further assess interest and capacity among partnering providers, a partner inventory survey was conducted.

The partners who completed our inventory collectively served at least 240,000 unduplicated Medicaid lives in primary care and behavioral health settings, community-based organizations, fire and rescue, and other support services in 2016. See Attachment 111. Because this partner inventory included almost all key Medicaid serving entities in the region, we estimate that their participation in this project would have the ability to reach at least 90 percent of the Medicaid population living in Pierce County. More will need to be done to identify and outreach to those Medicaid members not included in the partner totals (i.e. those not regularly accessing care).

Consideration on Level of Impact

Through extensive regional partners and organizations serving the cultural, linguistic and geographic diversity across Pierce County, PCACH expects to have significant improvement on performance metrics identified for the Chronic Disease Prevention and Control project area, including a reduction in health disparities. Subsequently, the following three criteria were applied to the identified populations to isolate the best-suited initial target population(s):

- Need: Does the priority population disproportionately experience poor health outcomes? Are there subgroups within the population that experience disparities? Is there a gap in existing services that could effectively address these outcomes?
- Impact: Is there strong potential for the project/intervention to improve outcomes for the population in 2-3 years? Is the priority population large enough for improvements to drive community-wide outcomes?
- Data feasibility: What data currently exist to explore the priority population, track outcomes,

and evaluate impact?

These metrics include:

- Emergency department visits per 1,000-member months
- Child and adolescents' access to primary care practitioners
- Comprehensive diabetes care: eye exam (retinal) performed
- Comprehensive diabetes care: HbA1c
- Comprehensive diabetes care medical attention to nephropathy
- Inpatient hospital utilization
- Medication management for people with asthma (5-64 years)
- Statin therapy for patients with cardiovascular disease

Health Equity

Health equity has been a foundational element in PCACH's Chronic Disease Prevention and Control project design and planning. To ensure that individuals facing the greatest health disparities inform the assessment of priorities and needed resources in the community, PCACH focused on engaging multi-sector partners representing the cultural, linguistic, and geographic diversity of Pierce County Medicaid members. These representatives have directly informed discussions and decisions regarding the CCM selection, identification of target populations, and PCACH Transformation Rules of Engagement for the Chronic Disease Prevention and Control project.

PCACH's Pathways Community HUB is expected to be a critically important asset for the successful pursuit of improved health outcomes for individuals at risk for or experiencing chronic disease. Our approach to community-based care coordination through the Pathways Community HUB Model represents another opportunity for addressing health equity for individuals with chronic disease. For example, the opportunity to leverage and expand the role of community health workers through this evidence-based, Community Care Coordination model will deepen beneficiaries' access to culturally and linguistically responsive care.

In addition to PCACH's development of the Chronic Disease and Prevention project, we are also working to deepen our impact on health equity through additional cross-cutting strategies. For example, we will ensure that:

- Community training is available in multiple languages and across diverse cultural and geographical community sites

- A trauma-informed lens will be applied to all the project designs (as informed through a partnership with the Tacoma/Pierce County Health Department, which brings deep expertise in this area)

- The Board of Trustees receives intensive training on diversity, equity and inclusion

- An equity lens is applied to PCACH policies/procedures/systems (i.e., hiring processes established that enhance diversity and inclusion in PCACH workplace)

- Cultural humility and trauma-informed care are incorporated as essential components of the SI Team's work

- Diverse community partners define the needed resources to strengthen community resiliency and that these needs are addressed through the PCACH's Community Resiliency Fund

Lasting Impacts and Overall Benefit

As a result of PCACH and partnering provider's focus on chronic disease and prevention through the Demonstration, the following lasting impacts are expected which will benefit the region's overall Medicaid population:

- Deepened capacity and expanded skills related to continuous quality improvement

- Expanded infrastructure and resources (i.e. workforce, HIT/HIE, VBP contracts) to support system transformation that addresses chronic care prevention and treatment

- Deepened partnerships across heath systems and the community, at local, regional, and state levels with aligned focus for target populations and improvement efforts

- Identifying and enhancing community resources that are focused on addressing the social determinants of health of individuals and populations facing the greatest health disparities

Partnering Providers

Serve a Significant Portion of Medicaid

Based on analysis of provider claims data provided by HCA, PCACH is working directly with partnering providers representing the highest Medicaid billers in each major setting (primary care, behavioral health/substance abuse, inpatient and ED). Three of the main health systems who care for the majority of Medicaid beneficiaries in the region—MultiCare, CHI Franciscan, and Sea Mar—are at some stage of implementing chronic disease management into their provider practices. All are interested in participating in the CDM project. We have letters of interest from each major and minor provider in our region. We have received more than 40 letters of interest in addressing Chronic Care and Prevention—covering an estimated 90 percent of the Medicaid lives in Pierce County (as described above).

Commitment to Serving Medicaid

During spring 2018, PCACH will secure contracts with partnering providers and community-based organizations that will include a commitment to PCACH's Transformation Rules of Engagement and to serving the target Medicaid populations. PCACH plans for ongoing monitoring and continuous improvement through the SI Team, who will also provide ongoing oversight of providers to ensure that they are serving Medicaid populations and implementing strategies that are working to reach the desired outcomes for the target Medicaid populations.

Process for Engagement

PCACH has established the PIP to routinely engage a broad spectrum of partnering providers in the identification of regional needs and development of the proposed project to date. In 2018, our deep partnerships with providers, health systems, community-based organizations and other allied stakeholders will remain a focus throughout both the planning and implementation periods.

PCACH engagement strategies will also ensure that alignment with other efforts in the region and broader engagement with state and local officials, most notably local and state public health and social services.

MCOs Expertise

PCACH has been working with MCOs in multiple ways to leverage their expertise, identify areas of alignment, and ensure there is no duplication. MCOs have been active participants across all PCACH councils and workgroups. Through these roles, MCOs have directly informed discussions and decisions pertaining to the CCM adoption, identification of target populations, and development of PCACH's Transformation Rules of Engagement for Chronic Disease Prevention and Control project transformation partners.

In addition to this intentional and broad engagement, PCACH has met with each MCO over the past few months and has identified the following opportunities for deepened and coordinated work: 1) assessment and support to expand provider readiness for VBP contracts, 2) optimization of data sharing to inform monitoring and continuous quality improvement, 3) provider support regarding utilization of data to inform quality improvement efforts, 4) provider support regarding adoption of effective strategies to improve patient engagement, and 5) coordination between the Pathways Community HUB and Health Home models to ensure that member's needs are being met, duplication is avoided, and VBP methodologies are advanced.

Regional Assets

PCACH brings a rich network of behavioral health/substance use disorder providers, community-based organizations and emergency medical service (EMS) providers ready to partner in new ways to support the management of people with chronic disease. PCACH will bring these substantial assets and supports to achieve regional advancement of the CCM through building an improvement framework based on the Institute for Healthcare Improvement (IHI) Science of Improvement Model and developing the strategy to support continuous quality improvement capabilities and capacity in the partnering provider organizations. This strategy includes a SI Team (internal PCACH resource) and a Quality and Continuous Improvement Workgroup (QCI Workgroup), an external resource made up of quality improvement experts in the region, to ensure improved region-wide quality, efficiency, and effectiveness of care processes.

Examples of the assets by provider type include:

Physical Care/Primary Care Providers:

CHI Franciscan, MultiCare, Northwest Physicians Network, Sea Mar, Pediatrics Northwest, Planned Parenthood: All are interested in participating in this project and will dedicate leadership and staff to ensure success. They have all identified critical partnerships with community-based organizations, YMCA of Pierce County, diabetes educators, community and hospital-based education services, pharmacies, housing services, and environmental partners. Although Planned Parenthood (PP) does not currently provide chronic disease management services, they recognize the key role they could play in delivering preventive care and early identification of chronic conditions to their patients. This is an opportunity for PCACH to broker relationships between partnering providers to better serve PP's patient base and improve access and equity. There is opportunity to expand these services to other conditions and to tap into Pediatrics Northwest robust data analytics and informatics dashboards to expand educational services.

Behavioral Health/Substance Use Disorder Providers:

Comprehensive Life Resources, Greater Lakes Mental Health, Prosperity Wellness Clinic: Interest exists, but there is a lack of understanding about the critical link behavioral health (BH) and substance use disorder (SUD) providers can play in managing chronic disease. Opportunity exists for PCACH to encourage/incentivize BH/SUD partnerships with primary care providers and increase involvement in the Chronic Disease Management project.

Community-based and Emergency Service Organizations:

Point Defiance Aids Projects (syringe exchange), Samoan Nurses Organization of WA (community health worker organization), Sound Outreach Services, East Pierce Fire & Rescue, Tacoma Fire Department, West Pierce Fire & Rescue and Central Pierce Fire & Rescue: All are interested in participating, but need help building partnerships with clinical partners. Opportunities exist for PCACH to target people with co-occurring behavioral health and chronic disease at syringe exchange through the Hub and Spoke Program, administered by Northwest Integrated Health, and nine EMS agencies in Pierce County. EMS already delivers chronic illness control through its integrated case management project. This project overlaps with PCACH's Care Coordination project—the Pathways Community HUB model. We have identified opportunities to align with EMS's integrated case management to bolster their efforts with regional investments in a centralized, care coordination hub and through the development of the community health workforce.

Finally, the PCACH team brings extensive knowledge about the Pathways Community HUB Model which will be an important foundation and thread for the region's work to advance chronic disease prevention and control. PCACH has already invested substantial time and financial resources to ensure the successful implementation of the Pathways Community HUB Model, including early planning for and development of the Pathways' IT platform, preparation for certification, and approaches to budget forecasting and sustainability.

Anticipated Challenges or Barriers

Input from our provider community identified the biggest barriers to achieving this goal are an uneasiness over payment reform and fatigue from competing improvement concepts and programs. This stems from the lack of a common framework, roadmap, cohesive technical support, and coherent payment models for practice transformation. Additional barriers that have been identified include:

- Stigma: The experience of chronic disease, especially for marginalized populations, presents a challenge for improving their care and requires a coordinated, culturally responsive and trauma-informed approach

- Data sharing and communication: These elements are critical for all aspects of the CCM and current infrastructure does not meet the full needs of partnering providers

- Existing workforce skills and capacity are unable to keep up with demand and type of care that is required

- The social determinants of health and coordination of needs outside of the health care delivery system remains foundational elements of achieving improved health of targeted populations. Currently, they are not reimbursable within traditional financing models

- Lack of integrated services or well-coordinated care

- Poor alignment between incentives and quality measures make sustained attention or deep impact difficult to achieve
- Startup costs for building the technical infrastructure to support integration

Mitigating Risks and Barriers

Three mechanisms will mitigate these risks and overcome barriers: Domain I investments in HIT and workforce (related to information exchange and workforce); and the Transformation Rules of Engagement for partnering providers for the Bi-Directional Care Project; and the technical assistance and support that will be offered by the Strategic Improvement (SI) Team (related to training).

HIT/HIE Investments: PCACH will develop an approach to population health management systems (PHMS) that encompasses strategies to successfully capture, collect, analyze and exchange data, while utilizing the most efficient, cost-effective, and wide-reaching technology available. To realize our vision and develop this approach, we have employed a chief information and technology officer (CITO), to be shared with Southwest ACH; and contracted with Providence Health & Services' CORE for data services. Next steps will include:

- Convene an HIT/HIE workgroup comprising chief information officer/chief technology officer-level participants from participating providers/partners. This group will be staffed by PCACH's CITO and will be charged with developing a regional HIT/HIE plan, prioritizing initiatives, and making recommendations for investments in PHMS solutions

- Establish an Infrastructure and Systems Capacity Building Fund to provide resources for technology planning, purchasing, training, technical assistance, and ongoing maintenance and support for participating providers. We will adopt proven-technology systems that allow for new and innovative strategies to support transformation efforts.

Workforce Investments: PCACH plans to leverage the efforts of the Workforce Development Council to provide a high-level assessment of workforce capacity and gaps in Pierce County in order to develop a targeted approach to workforce needs for bi-directional care. Preliminarily, PCACH is considering the following solutions in this area:

- Telehealth and telepsychology as potential solutions to workforce gaps in urban and rural areas of the region

- Working with the Puyallup Tribe to explore ways to assist, encourage, and incentivize members of their clinical residency program to be retained within the region's workforce

- PCACH leadership is also exploring solutions to recently identified licensure barriers for the state's behavioral health residential treatment programs.

"Transformation Rules of Engagement": Starting in mid-2017, the PIP began developing White Papers on integration and primary care medical home. At the outset, the Transformation Rules of Engagement defines the expectations for partnering providers and partners throughout the region that are participating in bi-directional integration. It outlines design, practice change, tools and validated screening instruments, performance management, equity and inclusion, reporting requirements and other requirements for MTP. The goal of developing the Transformation Rules of Engagement early was to gain consensus, establish the expectations, and develop a reginal model while enabling the providers

and partnering organizations the opportunity to plan for practice and organizational change and upcoming delivery system change.

Strategic Improvement (SI) Team: The (SI Team is complementary in nature to the PIP in that it will be responsible for supporting the success of the project by providing the necessary trainings and support to engaged providers to ensure their successful implementation of the project. The SI Team will do this by arranging trainings, establishing learning collaboratives and other opportunities for shared learning across the project's partnering providers. Trainings will encompass what it means to provide integrated care and will evolve to meet the specific needs of the Medicaid population.

Monitoring Implementation Progress

PCACH is building a robust project monitoring and continuous improvement infrastructure and process to support the Demonstration project portfolio and a community-wide system of care by working collectively to achieve our targeted goals. The process for project monitoring and continuous improvement relies on several core components including: strong infrastructure of timely data, continuous data monitoring and analysis, and reporting at multiple levels including providers, community, ACH governance, and state levels. See Figure 21 for more details.

Figure 24. Process for Monitoring and Continuous Improvement
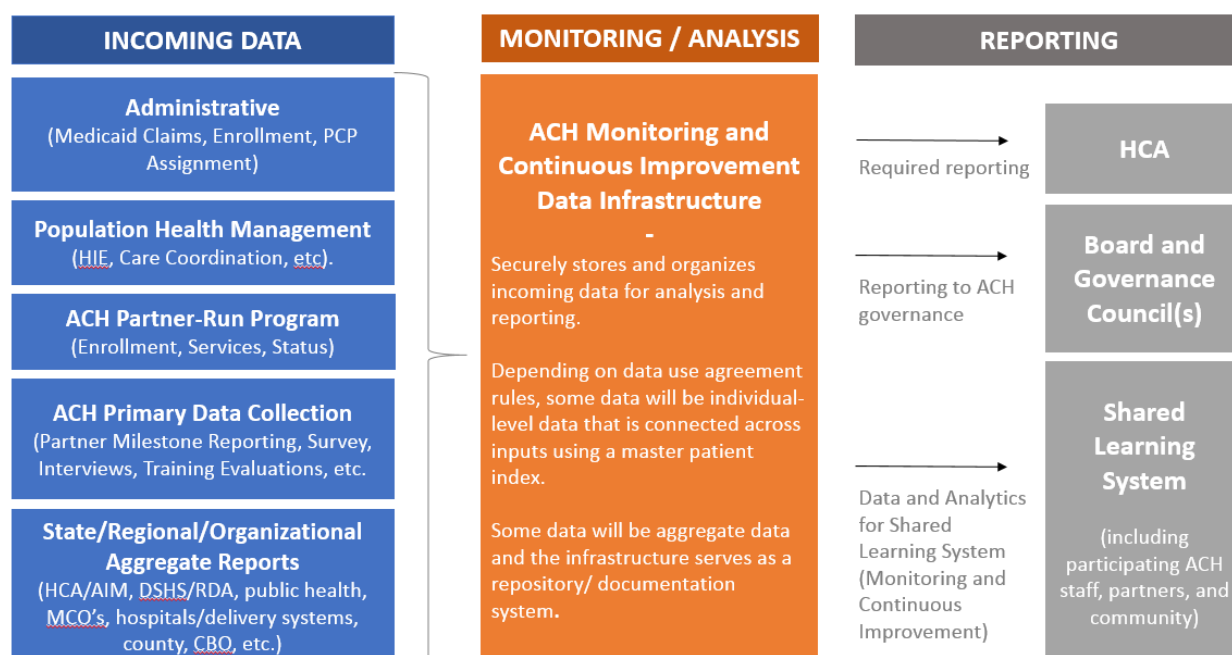
The data infrastructure to support monitoring and continuous improvement will be designed to complement existing data assets (such as the Healthier Washington Data Dashboards) and will build upon "point of care" population health management system inputs needed for projects. Among the incoming data in Figure 24 are the identified data sources associated with 1) pay for reporting (P4R) and pay for performance (P4P) metrics and 2) key data needed for analysis to support program implementation, monitoring, continuous improvement, evaluation/sustainability, and spread. PCACH has contracted with the CORE to design and run the monitoring system.

The PCACH monitoring and continuous improvement system will incorporate key process measures and

milestones for Chronic Disease Prevention and Control project implementation, as shown in Figure 21. Adjustments to implementation timelines will be triaged through this system and course corrected wherever possible. Implementation progress and status of timelines will be monitored by PCACH with clear lines of communication and accountability between partnering providers, PCACH Staff (SI Team), CORE, QCI Workgroup, PIP, Regional Health Improvement Plan (RHIP) Council and other PCACH's governance committees and board.

PCACH has developed an improvement framework (see attachment 110) based on the IHI Science of Improvement Model and has been actively developing the strategy to support continuous quality improvement system outlined above. PCACH is currently establishing an SI Team (internal PCACH resource) and a (QCI) Workgroup (external resource made up of quality improvement experts in region) to ensure improved region-wide quality, efficiency, and effectiveness of care processes. The improvement framework ensures the testing and feedback loop is supporting the progression toward improved population level outcomes. If initial timelines still cannot be met, PCACH will communicate a plan back to the state regarding reasons why timelines weren't met, a plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate. If there are specific policy or systems barriers PCACH governance will actively pursue solutions in partnership with the state.

Monitoring Continuous Improvement

PCACH will use the monitoring tools, improvement framework and the SI Team to develop out the comprehensive shared learning system that follows the best practice of a "Plan, Do, Study, Act" (PDSA) continuous quality improvement process. The shared learning and action will be the unified system of rapid cycle feedback and quality improvement across all the organizational partners and to ensure the successful progress toward milestones and outcomes and reporting is done in a timely and quality manner.

PCACH has developed a Strategic Improvement infrastructure that consists of improvement advisor that provide support for providers – across all projects – to achieve continuous improvement. The following content on the key general supports will apply across the board for projects, but project-specific supports like the exact trainings, tools, and technical assistance will vary by project and provider and will unfold as these teams undergo a process for developing specifics. The following content outlines the general supports and approach, the process for developing specifics (including some example specifics), and additional thinking and work done to date related to this topic.

Key general supports for partnering providers to achieve continuous improvement include:

1) PCACH-funded Data Analytics, Performance Monitoring, and Quality Improvement Processes and Programming. The following are examples of key general supports:

- Strategic advisement and technical assistance on defining project metrics
- Strategic advisement and technical assistance on data collection best practice and methods for tracking metrics and ensuring provider proficiency at reporting on required PCACH and MTP level reporting requirements (excel worksheet and electronic reporting questionnaire/survey with metrics and definitions) and regularly report on a monthly, quarterly and annual basis
- Strategic advisement on how quality and other metrics are measured and related technical assistance to improve reporting and documentation process

- Strategic advisement on how to improve quality outcomes and tools for achieving those outcomes
- PCACH-wide performance monitoring dashboards
- Where possible, data analysis of performance to understand what's driving performance rates and forecasting related to hitting targets
- Ensuring participating providers and partners have pay for reporting tools and capabilities in place
- Assessments on connectivity with various partners data including administrative data, MCOs, CCS (Pathways) platform and Chronic Disease, etc. for data and pull together (with CORE's oversight) for regional dashboard
- Ensuring shared learning system is accelerating implementation, spread, and scale-up of innovative approaches to improving health outcomes

In addition to the Data Analytics, performance Monitoring, and Quality and Continuous Improvement, PCACH is funding Strategic Improvement Team consisting of Improvement Advisors and Continuous Quality Improvement workgroup. These resources will leverage the data provided to guide their efforts in providing technical assistance, practice coaching, and trainings to the providers.

The system will be informed by key planning inputs, including the SI Team, that better informs and positions the QCI Workgroup to make recommendations to the PCACH leadership to invest in and provide key supports to providers and organizations, ensuring they are meeting the goals of each phase. This system will incorporate tools for data collection and monitoring that are dynamic and flexible, calibrated to effectively meet the needs for each evolving stage of the Demonstration for each project area.

Identification for Initiatives or Strategies Not Working

The comprehensive shared learning system and PDSA continuous improvement process will support PCACH and our partners to rapidly identify opportunities for course correction and adjusting strategies to meet our targeted outcomes. Any strategies identified as not working or achieving outcomes will be brought to the QCI Workgroup immediately for review.

PCACH-funded Strategic Improvement Team (SI Team) and Quality & Continuous Improvement Workgroup (QCI) will provide support for rapid cycle feedback and quality improvement (Improvement Framework and Science of Improvement model, see Attachment X and X provided in our original project plan submission) the following examples of key general supports:

- The Strategic Improvement Team will work together with our provider practices and partners to ensure that all improvement efforts include, IHI's Science of Improvement steps:
  - A clear, measurable aim (focused on MTP projects are at the center - i.e. integration, opioid, chronic disease, transitional care, diversions)
  - A measurement framework in support of reaching the aim o A clear description of the ideas (content) and how these ideas are expected to impact the results (the causal pathway from changes to desired outcomes)
  - A clear description of the execution strategy (what will be done to ensure reliable adoption of the content?)
  - Dedication to rapid testing (PDSA cycles), prediction, and learning from tests

- o Understanding, describing, and visualizing systems (e.g., using a process map or value stream map)
- o Learning from variation and heterogeneity
    - Use of time-ordered data to detect special cause and improvement
    - Understanding why results differ by location (ward, organization, etc.)
- o Application of behavioral and social sciences
- o Application of pay for reporting tools for improvement and waiver project reporting to enable payment and progress toward improvement
- o Building science-based improvement capability at provider, team, clinic-wide and system level
- o Ensuring quality improvement knowledge and skills are provided to participating providers and health care workforce
- o Ensuring the capability of teams to use advanced improvement methods that guide and support front-line improvement for participating providers;
- o Providing a clear roadmap for how organizations using Lean and Six Sigma can use the science of improvement to accelerate results

• The Quality & Continuous Improvement Workgroup will be an external team made up of quality and clinical improvement individuals in regional partnering organizations that support the quality improvement activities associated with PCACH's transformation efforts.

- o QCI Workgroup comprised of Quality and Clinical Improvement level participants from participating providers/partners, staffed by Director of Strategic Improvement;
- o Establishment the Systems and Capacity Building Fund to provide resources for quality improvement education, training, technical assistance, education, practice improvement and support for participating providers; and
- o Adoption of Science of Improvement methodology that allow for new and innovative strategies.

Project-Specific Supports: The above content describes the general approach to supporting providers for continuous improvement. Due to the timing of writing this project plan and PCACH progress on hiring and staffing these key roles to facilitate deeper development of specifics, PCACH has not had staff in place long enough to articulate all of the project-specific measures, trainings, tools, etc. that they will provide, though PCACH was proactive at assessing each providers specific needs, there has not be time to develop a resulting tailored QA plan.

That being said, PCACH can articulate the process by which they will develop more specific supports.

This process includes:

- • Phase I Partner Inventory (COMPLETE) - PCACH has completed and reviewed a starting inventory of partnering provider interests, needs, and goals as it relates to the Demonstration project areas. This Phase I Partner Inventory was a 12-page document, exploring individual organization's interest and barriers to participation in MTP. The inventory was sent out in September 2017 to more than 70 different types of organizations, such as clinical providers, hospital systems, behavioral health providers, EMS, and community-based organizations. PCACH received over 30 responses, with approximately 10 from clinical providers and hospital systems, 10 from behavioral health providers and 10 from community-based organizations. This

information has provided a starting point for the SIT to plan specific TA, training and education.

- Phase I Partner / Provider Guided Discussions for Portfolio Development (COMPLETE) – PCACH followed up with key providers to have more in-depth discussion based on inventory responses.
- Develop and Adopt Rules of Engagement (COMPLETE) - PCACH has developed and adopted Rules of Engagement that outline expectations of providers under the Demonstration. These rules will provide clarity on specifics so that the SI Team can develop a corresponding plan for support and identifying risks.
- Phase II Partner Inventory/Assessment (Upcoming) – PCACH will conduct a formal "current state assessment" across all projects that will provide an up-to-date inventory of current state and barriers/haps to achieving future state expectations (rules of engagement) and additional conversations for the implementation design phase.
- Implementation Design Phase (Under development and deployment upcoming) – PCACH will continue to engage providers during the implementation design phase. This engagement will involve developing out a plan for quality improvement and technical assistance (a strategic improvement toolkit) needed from providers to be successful in achieve milestones and outcomes by project.

Example 1:

- Partnering Provider A identifies in their inventory that they lack the technical systems needed to fulfill required reporting for a project area.
- PCACH has a follow up guided discussion with the partnering provider to understand why these systems are not in place – documenting the barriers and supports needed. This information goes into PCACH's planning process, of all provider barriers and supports that feed into PCACH's Strategic Improvement Team's
- PCACH developed out and governance structure and then the Board adopted the Rules of Engagement so that there are clear required expectations of that provider to fulfill the reporting while simultaneously co-developing with the provider- in planning and further development the implementation design phase, a plan for providing assistance to build up the providers capacity to fulfill reporting requirements. This could include strategic advisement and TA on tracking the right inputs and extracting reports from their existing systems.

Real-Time Data / Day-to-day Performance

To date PCACH has explored options for data inputs for monitoring and quality improvement including proxy measures for performance monitoring and QI when ideal inputs may be unavailable. PCACH's goal is to identify data sources and/or processes that will help PCACH track provider/partner progress and/or activities that will lead to improvement for the pay for performance measures.

Problems – Access to Timely Data/Reports for Performance Monitoring and Analysis many of PCACH pay for performance measures will be subject to claims lag and other processes that will prevent PCACH from being able to monitor performance progress on these metrics in a timely manner. PCACH will also need access to data or reports on the metrics that will allow them to analyze the data to do things like identify disparities by population (are there specific populations that have

lower rates of well child visits?), geography (are there differences in rural or urban communities on well child visits?), or provider (are there differences by clinic in well child visit rates?)…and the interaction of these factors that could lead to identifying more complex issues.

Example: A key input for monitoring and QI could be Administrative Data on Medicaid Population through Medicaid Claims / Enrollment – the data source for the majority of the pay for performance metrics. Though this information is not real-time, it could be used for metrics forecasting.

Providence CORE has a metrics and forecasting team that specializes in forecasting metric rates, though again, as PCACH's data analytics vendor, PCACH has been told that they cannot put agreements together to give their data analytics vendors access to these data for monitoring and QI.

Possible Solutions – Develop Proxy Measures and Data Sources: Despite barriers to access to data, PCACH will continue to work through the metrics and identify data sources and processes that could be explored as proxy sources (e.g. which health care settings are key to this metric? which project area implementation steps or program workflows and data that could have QIP metrics added to them?).

Examples:

1. ED Visits: Could a region reliably monitor ED visits through EDIE data as a proxy data source for the P4P ED measures? I mentioned the challenge of trying to translate EDIE data to a proper rate per member or rate per 1,000-member months would take some thinking. Since most of the performance measures have layers of criteria for inclusion and exclusion (especially those that rely on coverage or other utilization in claims) that a proxy data source may lack, there will be some instances where this will be more worthwhile/feasible than others. Continuing with this example, would we be able to explore EDIE data for patterns by population, geography, and/or emergency department? And for an ACH that might be interested in a monitoring approach that has a public surveillance lens to it – that ACH might leverage data like these to do more real time community wide monitoring of emergency department use trends.

2. Clinical Processes: identify clinical processes that could be

adapted and tracked to ensure that we see change within clinics that ought to lead to performance improvement. This falls squarely into the world of QI.

3. Measures of Care Coordination: I mentioned that measures of care coordination will often have other systems where activities are tracked that could serve as process data. For example – in Oregon there was a program that the county ran to follow up with people who were hospitalized for mental illness. It was the goal of the program to do this within 7 days (which was the CCO's P4P measure). To run this program, they had real-time data of hospital admissions and tracked their program team's follow up activities, including if they got people into outpatient care. This kind of process/program data could be a good monitoring source for the related HEDIS measure 7-day Follow Up After Hospitalization for Mental illness.

4. EHR Data – The SI Team will work directly with providers so that they themselves are being trained to use their own data to monitor their day to day performance. The ACH is hopeful that this could be the source of performance monitoring at a provider level, but will process with cautious as this solution provides an additional upfront burden on providers, though would provide long-term use for providers.

5. MCO Contract Measures: MCO's already monitor provider performance on many P4P measures. How do we best leverage this work? To date, MCO's have expressed to PCACH that this option is not preferable.

Project Sustainability

We see sustainability on several levels. First is to bolster provider capacities to enhance care collaboration and be ready for the world of VBP. PCACH is working closely with partners to build internal capacity and capabilities that will lead to long-term system transformation with regards to chronic disease prevention and control. PCACH is facilitating new linkages between providers and CBOs and expects that these partnerships will become part of the infrastructure and an accepted way of doing business within the Chronic Care Model. In addition, PCACH is working with providers to move from volume to value to transform practices. To do this, PCACH and its SI Team will utilize a variety of process improvement and change management strategies to support practices to make sustainable change. They also will support providers with performance management tools providing a roadmap for the expansion of internal capacity and capability building to help them meet established success measures and outcomes.

The second level of sustainability is more external—understanding and supporting the social, physical and economic barriers that are so closely linked to poor health status. PCACH's Community Resiliency Fund will be created to meet this challenge. During the Demonstration, PCACH will build the vision, strategy, partnerships, and capacity necessary to spearhead this initiative. The Fund will focus on regional, community-led initiatives aimed at strengthening resiliency through social determinant investments and necessary policies and system changes for overall population health. The Community Resiliency Fund will deepen and strengthen existing investments as well as provide a model for future investments, one that builds off PCACH's infrastructure and vision and is adaptive to the changing landscape.

Impact Beyond MTP

Through our work, PCACH is seeking not to solely fund projects, but to build a model for our region to create a healthier community. We see promise in an approach that starts with the Medicaid program, and spreads to Medicare and to the commercial market. We expect that our deep collaboration with providers, CBOs and other stakeholders will lead to real transformation within and beyond the health system and set a standard for the health landscape in our region and our state.

Supplemental Workbook

Implementation Approaches

2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity of Integrated Care Model Adoption: Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the five levels of collaboration as outlined in the Standard Framework for Integrated Care (http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf).	**DY 2, Q2**	*PCACH staff, the Provider Integration Panel (PIP), deep-dive partner work sessions, Opioid Workgroup, Care Coordination Advisory Workgroup, Data & Learning Team and the Regional Health Improvement Plan Council (RHIP) have developed and adopted the Transformation of Care and Service Delivery Settings, Transformation Rules of Engagement (that serves across settings and provides clinical-community linkages). (see Attachment 1.) Aims and Drivers (see attachment 2) and Science of Improvement methodology (see attachment 110) that delivers a solid foundation for the implementation preparation. In addition, several clinicians serving on the PIP have co-authored white papers providing guidance on bi-directional integration of physical and behavioral health (comparing and contrasting Collaborative Care Model and Bree Collaborative overlays, providing a guide for a blended model in Pierce County), the Wagner's Chronic Care Model and Primary Care Medical Home. The white apers, tools and rules of engagement serve as our MTP roadmap and have been placed into PCACH's draft Transformation Action Plan. The Action Plan is guiding our implementation preparation for the regions partnering providers. The PIP and RHIP Council have adopted the evidence-based approach of Collaborative Care Model (CoCM) with overlays of Bree for Pierce County. PCACH's Board has adopted the recommendations including the Transformation of Care and Service Delivery Settings, Transformation Rules of Engagement, regional Aims and Drivers, and Science of Improvement Methodology. PCACH received 30 Phase 1 Partner Inventories, conducted several Guided Discussions with providers, and received 38 Letters of Interest from traditional and non-traditional providers to participate in MTP, which covers approximately 90% of our Medicaid lives in Pierce County.*

		In DY 2, Q1 PCACH will continue to design, test, refine and conduct a Phase II Partner Inventory for clinical providers and community-based organizations (CBOs). PCACH will further analyze the Phase 2 results and categorize providers. The settings to transform will be the guide post for our region. The providers will be tiered and placed into cohorts based on adoption. In DY 2, Q1 PCACH will launch a Strategic Improvement (SI) Team to support providers and partners with the Science of Improvement methodology, to ensure targeted and focused strategies are deployed that support the partnering providers and organizations based on their tier and level of need. PCACH has built a shared learning structure that engages numerous stakeholders, including provider organizations that engage iteratively and deeply. PCACH will seat a Quality and Continuous Improvement Workgroup comprised of multi-sector stakeholders with backgrounds in quality and clinical quality improvement to vet the work of the SI Team and the products emanating from the team's work. In DY 2 Q1-2 the SI Team will begin supporting providers through the implementation planning period and in DY 2 Q3-4, the SI Team will assist partnering providers by ensuring science of improvement methodologies are carried out within the region; pay for reporting tools to support providers and partners; connection with available and new resources to ensure capabilities and capacities are built for sustainability; and coordinate with both HIT/HIE for connectivity and the DLT to ensure data, reporting and evaluation are aligned as we implement. PCACH will seek councils, panel and board approval.
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	**DY 2, Q2**	In early DY 2, Q1, PCACH will continue to evolve the work of the PIP and RHIP Council to launch targeted taskforces for Workforce, population health management systems (PHMs), and value-based payment (VBP) to ensure we develop strategies and implement approaches that support each project area as noted below:

| | | Workforce:
In DY 1, Q4, PCACH will take part in a statewide workforce forum established for ACHs and subject matter experts to collaborate on shared approaches, tools, resources, planning, and deployment across ACHs. PCACH teams and workgroups will utilize tools and guidance provided by this forum in regional planning and implementation. PCACH will also learn from and align with Workforce Central (an organization that coordinates, administers and advances the efforts of WorkSource Pierce) and the recommendations outlined in the Skills Gap Analysis and Sector Strategies for Pierce County. PCACH currently partners with the Pierce County Workforce Development Council and will utilize that connection to access local workforce data, learn about and help develop local initiatives, and align with existing regional assessment efforts. PCACH will use State and local resources to better understand the workforce capacity to identify gaps in the primary care, behavioral health, substance use disorder treatment system, community-based organizations and recovery support system; and develop initiatives to attract, train, and retain skilled professionals. |
| | | Population Health Management:
In DY 1, Q4, PCACH, in collaboration with SWACH, hired a shared chief information technology officer to further develop out our regional population health management strategy (PHMs). PCACH has completed an initial assessment of regional providers through our partner inventory including MultiCare, CHI Franciscan, SeaMar Community Health Centers, Pediatrics Northwest, Community Health Care, Greater Lakes Mental Healthcare, Hope Sparks, Consejo Counseling & Referral Services Northwest Physicians Network, Northwest Integrated Health, Pioneer Health, Lutheran Community Services NW, Prosperity Wellness Center, Planned Parenthood GNHI, Tacoma-Pierce Health Department, Emergency Food Bank, Tacoma Housing, Metropolitan Development Council, Catholic Community Services, Point Defiance AIDS Project, Korean Women's Association, First5Fundamentals, Center for Dialog Resolution, Children's Home Society, Comprehensive Life Resources, Pioneer Human Services, County-wide EMS, Pierce County Executive Office, Jails, Human Services, City of Tacoma Fire, Samoan Nurses Association, Sound Outreach, other provider and CBOs. |

| | | In DY 2, Q1, PCACH will conduct a PHMS gap assessment that will be used by the PHMS Team to build an approach including tools and resources needed to address gaps and support a regional interconnected infrastructure including data collection and analytics, health information exchange (HIE) and health information technology (HIT). Partnering with SWACH, PCACH will be systemic in the approach used to ensure providers are supported as the solution evolves. The DLT will support data and evaluation components and PCACH will utilize the SI Team, this will be built as a vibrant, IT-enabled, and sustainable shared learning system to accelerate implementation, spread and scale-up of innovative approaches to improving health outcomes for providers to support population health management strategies to ensure the partnering providers and CBOs have the tools they need for this focus area. They will connect available and new resources with providers to ensure capabilities and capacities are built for sustainability. |
| | | Value-based Payment:
 PCACH's VBP strategy includes the preparation by designing the SI Team, reviewing providers input from Phase one partner inventories, MVP survey and the engagement of MCOs, providers and stakeholders to start the groundwork development.
 PCACH initial VBP work will further inform our regional strategy development in DY 2, Q1. PCACH will launch the VBP Team under the PIP in DY 2, Q1. It will assist in the development of the VBP section of the Phase 2 partner inventory, set strategy for addressing current barriers to VBP adoption, and building upon highly functioning VBP modeling. The SI Team will support our providers and partners, so they are integrated into improvement science by ensuring: science of improvement methodologies are carried out within the region; pay for reporting tools to support providers and partners through demonstration; connect available and new resources with providers to ensure capabilities and capacities are built for sustainability through VBP Team and partnering provider to develop out innovative approaches to scale and spread. |

Finalize target population(s) and evidence-based approach (es) informed by regional health needs	**DY 2, Q2**	*PCACH's DLT, PIP, Community Voice Council and RHIP Council (CVC) have adopted the draft initial target populations through the review of currently available data from various sources including a community-wide survey, interviews and partner inventory submission from providers serving Medicaid population (including primary care providers, behavioral health providers and substance use providers, non-traditional providers), CBOs serving the Medicaid population, health department, public data sources, MCOs and CVC. In DY 1, Q4 PCACH PIP recommended adoption 1) Collaborative Care Model with an overlay of 2) Bree Collaborative concepts for all partnering partners. They also adopted screening tools and bi-directional elements to support steps toward bi-directional integration. The RHIP Council and board also approved the initial recommendation.* In DY 2, Q1 and Q2, the DLT and PIP will further evaluate additional data to finalize the target populations. Members of the PIP have written several White Papers to inform the providers and community regarding evidence-based approaches that could be adopted in the Pierce County region. PCACH will seek councils, panel and Board approval. The Provider Integration Panel and subsequent councils, board will finalize approval of the evidence-based approach in DY 2, Q1.

Identify and engage project implementation partnering provider organizations, including: behavioral and physical health providers, organizations, and relevant committees or councils -Identify, recruit, and secure formal commitments for participation from all target providers/organizations via a written agreement specific to the role each will perform in the project.	DY 2, Q2	*In DY 1, Q4 PCACH developed Transformation Rules of Engagement, a projec councils, panel and taskforces, and settings to transform that outlines partne benefits of partnerships. Initial partnering inventories have started the engag interest that includes commitment to working with PCACH, the various team providers have submitted letters of interest, including:*

- Catholic Community Services
- Center for Dialog & Resolution
- Central Pierce Fire & Rescue
- CHI Franciscan Health
- Children's Home Society
- City of Tacoma Fire Department
- Community Health Care
- Comprehensive Life Resources
- Consejo Counseling & Referral Services
- Crisis Clinic
- East Pierce Fire & Rescue
- Emergency Food Network
- First5Fundamentals
- Gig Harbor Fire & Medic One
- Graham Fire & Rescue
- Greater Lakes Mental HealthCare
- Hope Sparks
- Korean Women's Association
- Leaders in Women's Health

- Lutheran Community Services Northwest
- Metropolitan Development Council
- MultiCare
- Northwest Integrated Health
- Northwest Physicians Network
- Orting Valley Fire & Rescue
- Pediatrics Northwest
- Perinatal Collaborative of Pierce County
- Pierce County Office of the County Executive
- Pioneer Human Services
- Planned Parenthood GNHI
- Point Defiance Aids Project/ NASEN
- Prosperity Wellness Center
- Samoan Nurses Organization (SNOW)
- Sea Mar Community Health Centers
- Sound Outreach
- Tacoma-Pierce County Health Department
- United Way of Pierce County
- West Pierce Fire & Rescue

PCACH has secured initial commitment prior to DY 2 but will further deepen PCACH and all partnering providers, CBOs and other stakeholders.

Develop project implementation plan, which must include: **-Implementation timeline** **-Selected evidence-based approaches to integration and partners/providers for implementation to ensure the inclusion of strategies that address all Medicaid beneficiaries (children and adults) particularly those with/or at-risk for behavioral health conditions** **-Justification demonstrating that the selected evidence-based approaches and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region** **-Description of how project aligns with related initiatives and avoids duplication of efforts** **-Roles and responsibilities of implementation partners: should include key organizational and provider participants that promote partnerships across the care continuum, including payer organizations, social services organizations, and across health service settings.** **-Describe strategies for ensuring long-term project sustainability**	**DY 2, Q3**	During DY 2, Q1 and Q2: PCACH staff, PIP, RHIP, CVC, DLT and the existing and numerous new workgroups will finalize the development of and approve the Transformation Action Plan that will drive our region's transformation efforts. Our Transformation Action Plan will: o Reconfirm regional expectations for care transformation through the settings approach, including building upon existing high functioning assets within region o Utilize approved roadmap and tools for bi-directional physical and behavioral health providers o Provide detailed requirements for provider participation including alignment with all project areas (transitions, diversions, chronic disease, care coordination, opioid, maternal/child health and oral health) o Provide contracting requirements for engagement in MTP o Establish Action Plan phased timing o Establish benchmarks for inputs and engagement with community, providers, and partners prior to and throughout implementation to ensure the Action Plan remains responsive to the needs of the region and our high-need populations. o Ensure our adopted strategy of elevating the voice of those most impacted and engendering the trust of the community remain in all transformation settings o Establish additional vetting mechanism for primary care, behavioral health, SUD providers, CBOs, law enforcement and criminal justice, EMS, and nontraditional providers to assess impact and feasibility of innovations o Outline steps to secure resources required to meet the Transformation Rules of Engagement o Establish requirements for utilization of and support by SI Team o Establish plan that incentivizes new behaviors of partnerships with non-traditional providers o Ensure framework for continuity and integration to disrupt traditional silos for the Action Plan to influence appropriate but diverse settings o Establish requirements and supports for reporting and self-monitoring system o Require final approval through the governance councils and board

		Both PCACH's PIP and RHIP Council have adopted the Collaborative Care Model with elements of Bree Collaborative recommendations after months of working together to do-develop the Transformation Rules of Engagement. The providers and community partners discussed gaps, duplication and silos within the region and developed tactics to start addressing during the implementation period. Through our Phase 1 Partner Inventory and subsequent guided discussions with executive and provider leadership a majority of our provider and partner organizations, we scanned and developed an asset map for the region to ensure we build our Action Plan to address gaps and benefit from assets and promising practices already in the region. We will conduct a Phase 2 Partner Inventory/Assessment in DY 2 Q1 that will deepen our knowledge and understanding of our community needs and assets.We will continue to work closely with MCOs, Optum (our current behavioral health organizations (BHO) transitioning out by 2019), providers and CBOs to ensure our Domain 1 strategies are capitalized and leveraged to make the largest impact and be sustained. PCACH's director of strategic improvement and the SI Team will ensure providers have the resources and support to build internal capability and capacity for long-term change and sustainability. We are currently collaborating with some ACHs on key areas including shared learning and care coordination and look to deepen our collaboration with more ACHs interested in shared learning and shared capacity as we move toward implementation.

Engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care **-Plan should reflect how the region will enact fully integrated managed care by or before January 2020** **-For regions that have already implemented fully integrated managed care, implementation plans should incorporate strategies to continue to support the transition**	**DY 2, Q4**	*In DY 1, Q1 PCACH began working with County Executive, MCOs, behavioral health providers, Primary care providers, SUD and numerous multi-sector agencies to prepare for fully-integrated managed care (FIMC). In DY 1 Q2, PCACH adopted our tribal engagement policy, had tribal education and have since been following the policy by sharing all documentation regarding PCACH with the Chairman of Nisqually Tribal Nation and Chairman of Puyallup Tribal Nation as well as the leaders of their health systems.* In DY 2, Q4 PCACH will continue to work closely with the county, MCOs, providers and other critical partners to support the development and implementation of Pierce County's transition to FIMC. The County Executive will be appointing a Pierce County Integration and Oversight Board and has appointed the Executive of PCACH to sit on this five-to-seven-person board ensuring tight collaboration between the county, MCOs and PCACH and partnering agencies throughout the transition to FIMC. PCACH will work closely with MCOs and VBP Team, PIP to develop a plan and engage all providers that serve the Medicaid population to ensure that the project portfolio progress is assessed, areas for improvement are developed, performance on VBP quality metrics are monitored and support the providers as they transition to new VBP models through contracts and change management support. PCACH will review and collaborate to improve proposed incentive models for providers adopting. PCACH will ensure that SI Team will support the efforts with the VBP Team, PIP, providers and partnering agencies.
Stage 2: Implementation		

Develop guidelines, policies, procedures and protocols	DY 3, Q1	DY3, Q1: In partnership with community and providers, PIP, RHIP Council, CVC and workgroups, PCACH Medical Officer and staff will validate the foundational roadmap developed and adopted in DY1 Q4. The establishment of guidelines, policies, procedures and protocols "regional playbook" will be adopted for use with the participating providers and partnering community to ensure our participating providers and partners are implementing strategies consistently using evidence-based models and practices. We are developing our regional playbook by utilizing best practices and build from existing local, regional, statewide, national expertise and proven tools, guidelines, policies, procedures and protocols to ensure we are building a consistent solution that targets accountability and supports transformation in the region. This playbook will provide independent project specific connections (i.e. CoCM, SAMSHA) as well as intersect with remaining MTP projects best-practices tailored for the Pierce County region. In partnership with PCACH's Medical Officer, the PIP and partnering clinical providers will develop and validate a roadmap for evidence-based approaches that ensure integration and capabilities of primary care, behavioral health, substance use providers, post and acute care, law enforcement, criminal justice and EMS and will support the optional input of telehealth solutions. We will ensure critical practice protocols are reviewed by the PIP and independently by clinical providers, so they have time to provide feedback to design pathways that meet patient needs and are practical in the providers' practices, clinics and health system. The HIT/HIE Workgroup will co-develop the HIT/HIE guidelines for the playbook in order to ensure data needs requirements and are addressed across the system so investments can be made efficiently, and progress can be monitored. Our Director of Strategic Improvement and the Strategic Improvement (SI) Team will ensure associated providers and partners have access to and understand the playbooks rules and strategies for implementation. Monitoring and adherence to playbook will be performed by the SI Team in partnership with the Medical Officer.

Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected approaches.	**DY 3, Q2**	PCACH is developing a SI Team that will support the work of the Quality and Continuous Improvement Team (QCIT) starting in DY 2, Q2 to develop the foundation for QIP work in the region. The QCIT develop and recommend to the Provider Integration Panel a detailed QIP that PCACH will support through SI Team and processes to monitor each projects health impact. MCOs and PCACH will review the quality metrics and agree on quality reporting for VBP model. SI Team will work with DLT and Providence CORE along with providers to ensure reporting tools (i.e. surveys, matrix, dashboards) are built and deployed to support the providers and allow transparency and an opportunity for rapid-cycle improvements for QIP attainment.
Implement project, including the following core components across the approaches selected: **-Ensure implementation addresses the core components of each selected evidence-based approach** **-Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to perform their role in the integrated model.** **-Implement shared care plans, shared EHRs and other technology to support integrated care.** **-Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care models.** **-Establish a performance-based payment model to incentivize progress and improvement.**	**DY 3, Q4**	PCACH's SI Team will be responsible for project management, facilitation of project implementation and set up a reporting system that captures progress and supports the providers then reports the findings to the various councils, panel, Board and community. The SI Team will ensure that participating providers have the tools, technical assistance, training and the support they need to perform in the new integrated model of care. Ensuring shared learning system is accelerating implementation of innovative approaches, the SIT will support the implementation of care plans, EHRs and IT spread to scale. The SIT quality improvement strategies throughout the provider practices / clinics and partnering agencies to accelerate implementation, spread and to scale-up. PCACH will connect providers to new and available resources including secure current and additional practice transformation resources to ensure capabilities are in place for the launch and adoption of performance based payments. Building science-based improvement capability at provider, team, clinic and system levels, PCACH's SIT will regularly connect with providers and review resources to ensure that they have sufficient financial and technical support for integration and will implement monitoring and reporting processes for transparency and accountability.

Implementation of fully integrated managed care (applicable to mid-adopter regions)	DY 3, Q1	*PCACH supported MCOs in Pierce County's adoption of FIMC for go-live January 2019. In DY 1 Q4 PCACH worked closely with the County Executive and County Council to move the county toward mid-adopter status. The County Executive executed the binding agreement with HCA to move toward FIMC in January 2019 in November 2017. PCACH's executive will serve on a County Executive appointed governance board that will help guide the process from the county lens along with the PCACH toward FIMC.* Through the SI Team, PCACH will support MCO's in their development of fully integrated contracts with HCA by providing education to community stakeholders, review gaps and barriers that may hinder successful adoption. PCACH will convene stakeholders, MCOs, providers and the county to discuss, navigate and resolve issues. PCACH will utilize the shared learning system and secure best practices from other ACHs to incorporate into the region. PCACH will share information gleaned from the community with the MCOs to ensure integration moves smoothly and will seek to coordinate projects with MCOs care transformation efforts.
Stage 3: Scale & Sustain		
Increase adoption of the integrated evidence-based approach by additional providers/organizations	DY 4, Q4	PCACH will utilize the SI Team and to build provider capability and capacity utilizing the science of improvement methodology. Advanced improvement methods will guide and support front-line staff supporting providers and SI Team will coordinate with and secure practice transformation resources for providers. SI Team will develop and deploy semi-annual reports the showcase the Stage 3 indicators progress of the regional partners to limited to: o PCACH, the DLT along with partners and provider champions will capture and review data that will show gaps in provider participation especially providers with larger number of patients that have substance use and behavioral health diagnoses. o PCACH will do outreach and engage with providers with the goal to recruit and bring new providers into the cohort working toward integrated care across the settings. o PCACH will establish a recruitment schedule for outliers and will gather community, council and provider input to processes that are developed for outreach and adoption.
Identify new, additional target providers/organizations.	DY 4, Q4	See information above and build provider champions that are currently working on integrated care within the region to bring providers and organizations into the partnership. Continue to scan landscape to ensure the region has a high level of provider and partner participation.

Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required	**DY 4, Q4**	PCACH will launch in DY 2, Q1 the Quality & Continuous Improvement Workgroup (QCI Workgroup) – assimilated from quality improvement experts throughout the region) that will work with the DLT, PIP, SI Team to develop a regional dashboard. The QCI Workgroup will develop a regional quality plan that focuses on quality improvement, health impact, VBP performance, and workforce (development and stabilization). The QCI Workgroup and SI Team will continue to monitor the developed dashboard regional progress toward implementation and practice transformation. The SI Team will troubleshoot issues that arise and secure resources to support issues/gaps. PCACH and SI Team will work with partnering providers to ensure clinic or site-specific improvements are addressed as needed. The QCI Workgroup and PIP will monitor progress and adjust as necessary to support move forward.
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion **-Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.**	**DY 4, Q4**	*In DY 1, Q4 PCACH adopted the Science of Improvement Framework from The Institute for Healthcare Improvement that utilizes Improvement Advisors that support quality improvement within partnering providers practices and is rooted in a shared learning system.* The SIT will provide deep supports to design, implementation, rapid-cycle improvements, reporting, spread, scale and evaluation for providers. The team's efforts will intersect with other improvement methodologies to ensure providers and practices have the support they need to successfully deploy transformation project(s). PCACH SIT will secure open communication with practices and providers to ensure that needs and gaps are understood so resources can be deployed. The SIT will support across the cohorts/partnerships through the shared learning system enabling best practice development and distribution throughout region to accelerate implementation, spread and scale. SIT will bring in resources that allow for sustainability of improvements with the partnering providers.
Identify and document the adoption by partnering providers of payment models that support integrated care approaches and the transition to value based payment for services	**DY 4, Q4**	PCACH with Providence CORE will develop and establish annual survey to monitor partnering providers' performance management and adoption of payment models that align and support VBP transition.
Implementation of fully integrated managed care (applicable to regions that did not pursue early or mid-adopter status)	**DY 4, Q1**	[Milestone does not apply to PCACH as region is a mid-adopter region.]

2B: Community-Based Care Coordination

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively focus on the need for regional community-based care coordination	DY 2, Q2	• *PCACH launched the Care Coordination Advisory Workgroup in DY 1, Q3 as the key workgroup to assess the region's capacity to implement care coordination. Throughout DY 1, PCACH has also prioritized and provided engagement opportunities with PCACH councils and workgroups, managed care organizations (MCOs), and ad hoc meetings on the Pathways Community HUB, all which have included extensive discussion on the need for regional community-based care coordination. Additionally, as part of the planning process, partner inventories have been obtained by potential transformation partners. These inventories contain information regarding current capacity and needs for community-based care coordination. This information is driving the development of the model and ultimately how the transformation partners will incorporate with the model and one another*
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	• Throughout DY 1, PCACH has developed the Pathways Community HUB to ensure our strategies and approaches support each Domain I focus areas as noted below: o Population Health Management: Health Information Exchange (HIE)/Healthcare Information Technology (HIT) needs will be met through contract with Care Coordination Systems (CCS) to develop the HUB platform, this includes connectivity to Emergency Department Information Exchange (EDIE), Pre-Manage, and Washington Information Network (WIN) 2-1-1 o Workforce: specific attention to hiring, training and capacity development of community health care workers (CHWs) to build a regional, community-based care coordination workforce o Workforce: initial capacity building and training for pilot implementation will be completed by DY 2, Q2 o Value-based Payment: outcome-based payments are inherent to Pathways Community HUB model. Discussions are underway with the four prospective Care Coordination Agencies (CCAs) to detail the payment methodology and address concerns/needed supports for the new method of payments

Finalize target population and evidence-based approach informed by regional health needs	DY 2, Q2	• Initial target population (pregnant women) has been identified through PCACH's Data & Learning Team (D&LT), Community Voice Council (CVC), Regional Health Improvement Plan Council (RHIP), surveys, regional health data, community-based organizations serving the Medicaid population, public data sources, Managed Care Organizations (MCOs) and application of PCACH criteria. • In DY 2, Q4 we plan to expand our target population. Various PCACH councils and the board will finalize approval of the approach in DY 2, Q3.
Identify project lead entity, including: **-Establish HUB planning group, including payers.** **-Designate an entity to serve as the HUB lead.**	DY 2, Q2	• Care Coordination Advisory Workgroup (open to all interested parties) launched in DY 1, Q3 • PCACH designated as HUB lead and has built out staff capacity as of DY 1, Q2 to support launch of initial pilot in 2017 • A Community Advisory Board, as required by national certification, will be formed by DY 2, Q2
Identify and engage project implementation partnering provider organizations, including: **-Review national HUB standards and provide training on the HUB model to stakeholders** **-Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB** **-Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity**	DY 2, Q2	• PCACH has provided multiple opportunities for training on the Pathways Community HUB model at PCACH meetings throughout DY 1, specifically at the Care Coordination Advisory Workgroup and ACH panels/councils, as well as when requested by other organizations such as the Pierce County Perinatal Collaborative, WIN 2-1-1, the Hub and Spoke recipient, Northwest Integrated Care and at the Practice Transformation Support Hub Qualis Health conference in Tacoma • Meetings underway with HCA, MCOs, PCACH and other ACHs regarding coordination between Pathways Community HUB and Health Homes • Inventory of care coordination activities and potentially interested CCAs completed in DY 1, Q2 by Care Coordination Advisory Workgroup • Request for Proposal (RFP) developed and reviewed by CVC and Care Coordination Advisory Workgroup DY 1, Q3 • RFP released in DY 1, Q3. PCACH now undergoing 1:1 meetings with four prospective CCAs to ensure clear understanding of expectations, capacity, and any needed supports • Contract with CCAs expected by DY 1, Q4, which will assist in covering the salary of the care coordinator in the beginning year of the model

Develop project implementation plan, which must include: -Description of pathways, focus areas, and care coordination service delivery models, -Implementation timeline -Roles and responsibilities of implementation partners -Describe strategies for ensuring long-term project sustainability	DY 2, Q3	• Project implementation plan is currently being implemented in advance of pilot launch, scheduled for DY 2, Q1, which includes work with CCAs, Care Coordination Advisory Workgroup, Foundation for Healthy Generation, CCS and other PCACH governance groups. The progress being tracked and monitored through weekly conference calls with Dr. Sarah Redding, CCS representative, Adam Burite and online application SmartSheet • PCACH Board, RHIP Council and Care Coordination Advisory Workgroup have begun mapping sustainability opportunities. One-on-one MCO conversations are underway • Current projections, pending payers' willingness and ability to engage, have the PCACH Pathways Community HUB in the financially sustainable in 2019 – DY 3 and breaking even in 2020 – DY4 • Robust reporting and analysis will enable direct cost savings achieved by health care systems and the improved health outcomes of clients
Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols	DY 3, Q1	• Development of guidelines, policies, procedures and protocols are currently underway as part of PCACH's technical assistance contract with CCS; this is in alignment with prerequisites for national Pathways Community HUB certification. • Develop recommendations based on successful Pathway Community HUBs in other states • Draft template will be reviewed by the future Care Coordination Advisory Workgroup as well as with each of the four CCAs. Finalization will be complete by DY 2, Q1 prior to the launch of the pilot.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / pathways	DY 3, Q2	• PCACH is developing a Strategic Improvement Team (SI Team) that will support the work of the Quality and Continuous Improvement Team (QCIT) starting in DY 2, Q2. o The QCIT will develop and recommend to the Community Advisory Board and onto the Board of Trustees a detailed QIP that PCACH will support through SI Team and processes to monitor each projects' health impact. o MCOs and PCACH will review the quality metrics and agree on quality reporting for the Pathways Community HUB model. o SI Team will work with CCS and Providence CORE along with CCAs to ensure reporting tools (i.e. surveys, matrix, dashboards) are built and deployed to support the care coordinators and allow transparency with an opportunity for rapid-cycle improvements for QIP attainment.

Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ: **-Create and implement checklists and related documents for care coordinators.** **-Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.** **-Develop systems to track and evaluate performance.** **-Hire and train staff.** **-Train care coordinator and other staff at participating partner agencies.** **-Conduct a community awareness campaign.**	DY 3, Q4	• Development of HUB IT platform is currently underway through contract with CCS and will include checklist, tracking, and related documents for care coordinators • Care Coordination Agencies (CCAs) hire additional care coordinators, as needed in DY 2, Q1 • Care coordination trainings for all CCA care coordinators in DY 2, Q1 to be led by Dr. Sarah Redding and the Foundation for Healthy Generations • Referral agency training regarding Pathways Community HUB by DY 2, Q2 • Launch of pilot phase for Pathways Community HUB by DY 2, Q2 including initial IT platform tools (tablets) to be used by Care Coordinators for tracking all 20 Pathways when serving initial pilot population of pregnant women • Community Awareness Campaign to launch by DY 2, Q3 in partnership with the PCACH Communications Team, CVC, PIP and Care Coordination Advisory Workgroup • SI Team and QICT assess initial pilot progress, including any challenges, needed support or changes in approach/implementation, in planning for scaling in DY 3
Stage 3: Scale & Sustain		

Increase scope and scale, such as adding partners, focus areas or pathways		• PCACH will utilize the Strategic Improvement Team (SI Team) and the science of improvement methodology to address any gaps or challenges identified through initial pilot; extend contracting to additional CCAs for expanded capacity; scale efforts to reach additional target populations
		 • SI TEAM will develop and deploy semi-annual reports that showcase progress indicators of the regional partners:
		     o PCACH and the Data & Learning Team (DLT) along with CCAs and care coordinators will capture and review data that will show gaps in resources or services
		     o PCACH will do outreach and engage with CCAs to bring new CCAs into the HUB

Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required		• PCACH will launch in DY 2, Q1 the Quality & Continuous Improvement Team (QCIT – assimilated from quality improvement experts throughout the region) that will work with the DLT, Provider Integration Plan (PIP), SI Team to develop a regional dashboard • The QCIT will develop a regional quality plan that focuses on quality improvement, health impact, VBP performance, and workforce (development and stabilization) • The QCIT and SI Team will continue to monitor the developed dashboard regional progress toward implementation and practice transformation. The SI Team will troubleshoot issues that arise and secure resources to support issues/gaps. • Our proposed CQI approach meets national HUB certification requirements
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion		• Provide additional training, technical assistance or employ learning collaboratives as dictated through gaps identified in real-time Pathways data capture and through meetings with CCAs • Monthly care coordinator meetings will assess real-time challenges and successes as evident through Pathways data and IT platform • Additionally, PCACH's efforts will intersect with other improvement methodologies to ensure CCAs in tandem with providers and practices have the support they need to successfully deploy transformation project(s) • The PCACH SI Team will provide deep supports to design and implement rapid-cycle improvements, reporting, spread, scale and evaluation for Transformation Partners. The SI Team will support across the cohorts/partnerships through the shared learning system enabling best practice development and distribution throughout region to accelerate implementation, spread and scale. • This approach meets national HUB certification requirements
Identify and document the adoption by partnering providers of payment models that support the HUB care coordination model and the transition to value based payment for services.		• *Throughout DY 1, PCACH has had conversations with MCO partners around the sustainability and funding mechanism specific to the Pathways Community HUB model (outcome-based payments). Certain MCOs in Washington State are payers in other locations with mature HUBs and pay for Pathways/outcomes in those locations* • Expand capacity and experience with outcome-based payments of the CCAs through implementation support and SI Team guidance/support • Use HUB data to inform expansion of regional, value-based payment contracts that help to achieve improved outcomes for Medicaid beneficiaries

3A: Addressing the Opioid Use Public Health Crisis

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.	DY 2, Q2	*PCACH launched the Opioid Workgroup in DY1, Q2 to assess the region's capacity to impact the opioid public health crisis and make recommendations regarding potential strategies to the Provider Integration Panel (PIP). The group has met 1-2 times per month to review work underway in the region. The group also assessed strategy recommendations from the Bree Collaborative, Medicaid Transformation Project Toolkit, and Washington State Hospital Association for prevention, treatment, overdose prevention, and recovery support. The Opioid Workgroup, Provider Integration Panel (PIP) and the Regional Health Improvement Planning (RHIP) Council analyzed regional data and information from partner inventories outlining the assets, gaps, and needs of the region's behavioral health network. This information was used to create the PCACH Transformation Rules of Engagement and will ultimately inform the Partner Plans that will be put into place in DY2, Q2. This document contains strategies to address the opioid public health crisis. See Attachment 1.* In DY 2, Q1 PCACH will conduct a phase two partner inventory of clinical providers, substance use disorder and mental health providers, community-based organizations, criminal justice and law enforcement agencies, etc. PCACH will analyze the phase two results, categorize providers by care setting, and place them into cohorts. In DY 2, Q1 PCACH will launch a Strategic Improvement Team (SI Team) that will support cohorts with the Science of Improvement methodology to ensure targeted and focused strategies are deployed that support the partnering providers and organizations based on their tier and level of need. In DY 2 Q1-2, the SI Team will begin supporting providers through the implementation planning period and in DY 2 Q3-4. The SI Team will ensure that science of improvement methodologies are carried out within the region; pay for reporting tools to support providers and partners; connect available and new resources to ensure capabilities and capacities are built for sustainability; and connect with the Data & Learning Team (DLT) to ensure data, reporting and evaluation are aligned as we implement.
Identify how strategies for Domain I focus areas – Systems for Population Health Management/HIT, Workforce, Value-based Payment – will support project	DY 2, Q2	In early DY 2, Q1, PCACH will continue to evolve the work of the Opioid Workgroup, Provider Integration Panel (PIP), and RHIP Council and will launch three, targeted workgroups: Workforce Development, Population Health Management, and Value Based Payment, to ensure we develop strategies and implement approaches for the Opioid Project as noted below:

		In DY 1, Q4, PCACH will take part in a statewide workforce forum established for ACHs and subject matter experts to collaborate on shared approaches, tools, resources, planning, and deployment across ACHs. PCACH teams and workgroups will utilize tools and guidance provided by this forum in regional planning and implementation. PCACH will also learn from and align with Workforce Central (an organization that coordinates, administers and advances the efforts of WorkSource Pierce) and the recommendations outlined in the Skills Gap Analysis and Sector Strategies for Pierce County. PCACH is currently partnering with the Pierce County Workforce Development Council to access local workforce data, learn about and help develop local initiatives, and align with existing regional assessment efforts. PCACH will use State and local resources to better understand the workforce capacity to identify gaps in the primary care, behavioral health, substance use disorder treatment system, community-based organizations and recovery support system; and develop initiatives to attract, train, and retain skilled professionals *In DY 1, Q4 PCACH in collaboration with South West Accountable Community of Health hired a shared Chief Information Technology Officer to further develop out our regional population health management strategy (PHM). PCACH has completed an initial assessment of regional providers through our partner inventory including MultiCare; CHI Franciscan; Sea Mar Community Health Centers; Pediatrics Northwest; Community Health Care; Greater Lakes Mental Healthcare; Hope Sparks; Consejo Counseling & Referral Services; Northwest Physicians Network; Northwest Integrated Health; Pioneer Health; Lutheran Community Services NW; Prosperity Wellness Center; Planned Parenthood GNHI; Tacoma-Pierce Health Department; Emergency Food Bank; Tacoma Housing; Metropolitan Development Council,; Catholic Community Services; Point Defiance AIDS Project; Korean Women's Association; First 5 Fundamentals; Center for Dialog Resolution; Children's Home Society, Comprehensive Life Resources; Pioneer Human Service;, Pierce County-wide EMS systems; Pierce County Executive Office, Jails, Human Services; City of Tacoma Fire; Samoan Nurses Association; Sound Outreach; other provider and CBOs.*

| | | In DY 2, Q1 PCACH will conduct a Population Health Management gap assessment that will be used by the PHM Team to build an approach including tools and resources needed to address gaps and support a regional interconnected infrastructure including data collection and analytics, health information exchange (HIE) and health information technology (HIT). Partnering with SWACH, PCACH will apply a systemic approach to ensure providers are supported as the solution evolves. The Data & Learning Team will support data and evaluation components and PCACH will utilize the Strategic Improvement Team as a vibrant, IT-enabled, and sustainable shared-learning system to accelerate implementation, spread and scale-up of innovative approaches for providers to support population health management strategies. The Strategy Improvement Team will connect available and new resources with providers to ensure capabilities and capacities are built for sustainability.

PCACH's Value Based Payment strategy includes the preparation by designing the Strategic Improvement Team, reviewing providers input from phase one partner inventories, Medicaid Value-based Payment survey and the engagement of Managed Care Organizations, providers and stakeholders to start the groundwork development. The Opioid Workgroup will work closely with Domain 1 workgroups to propose payment mechanisms that support broader access to MAT and the services necessary to prescribe MAT in non-traditional settings.

In DY 2, Q1 PCACH's initial VBP work will further inform our regional strategy development. PCACH will launch the VBP Team under the Provider Integration Panel to assist in the development of the VBP section of the phase two partner inventory, set strategy for addressing current barriers to VBP adoption, and build upon highly-functioning VBP modeling. The Strategic Improvement Team will support our providers and partners so they are integrated into improvement science by ensuring that science of improvement methodologies are carried out within the region; paying for reporting tools to support providers and partners through the Demonstration; connecting available and new resources with providers to verify capabilities and capacities are built for sustainability through VBP Team and partnering provider to develop out innovative approaches to scale and spread. |

Finalize target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse and abuse.)	DY 2, Q2	*PCACH's Data & Learning Team, Provider Integration Panel, Community Voice Council, RHIP Council, and Opioid Workgroup have adopted draft of initial target populations across our project areas through the review of currently available data from various sources, including a community-wide survey, interviews and partner inventory submission from providers serving the Medicaid population (such as primary care providers, behavioral health providers and substance use providers, non-traditional providers), community-based organizations, health department, public data sources, MCOs and Community Voice Council. Preliminary target populations were chosen based on levels of disease burden, untreated opioid use disorder, and inequity.* *In DY 1, Q4 the Provider Integration Panel approved the Transformation Rules of Engagement, including the strategies to address the opioid public health crisis and the preliminary target population recommended by the Data & Learning Team and the Opioid Workgroup. The RHIP Council and Board also approved the Transformation Rules of Engagement.* In DY 2, Q1 and Q2, the Data & Learning Team and Provider Integration Panel will evaluate additional data to deepen and fine-tune the target populations. PCACH will seek councils, panel and board approval. The Provider Integration Panel and subsequent councils, and board will finalize approval of the evidence-based strategies in DY 2, Q2.
Identify and engage project implementation partnering provider organizations, including: **-Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist.** **-Identify, recruit, and secure formal**	DY 2, Q2	*In DY 1, Q4 PCACH developed the Transformation Rules of Engagement, including the strategies to address the opioid public health crisis, with deep engagement from community, councils, panel and workgroups that outlines partnering provider project requirements, expectations and benefits of partnerships. Initial partner inventories have been conducted, with nearly 40 cross-sector organizations responding to questions regarding current capacity to address the opioid use crisis.*

commitments for participation in project implementation including professional associations, physical, mental health and substance use disorder, (SUD) providers and teaching institutions.		*In DY 1, Q4, PCACH also sent a request to the community, soliciting letters of interest and commitment to work with PCACH in the implementation planning phase. 38 providers submitted letters of interest to work with PCACH in addressing the opioid public health crisis. These include mental health and substance use disorder agencies: Comprehensive Life Resources, Greater Lakes Mental Health, Pioneer Human Services, and Prosperity Wellness, and Northwest Integrated Health (Hub and Spoke, which includes spoke agencies Olalla Recovery Centers, Puyallup Tribal Authority, Pierce County Alliance, and Nisqually Tribal Health). Physical health providers include CHI Franciscan, Community Health Care, MultiCare Health System, Northwest Physicians Network Pediatrics Northwest, Planned Parenthood, and Sea Mar Community Health Centers. Community based organizations include Catholic Community Services, First 5 Fundamentals, Hope Sparks, Korean Women's Association, and Point Defiance AIDS Projects-Tacoma Needle Exchange. Emergency Medical Services include Central, East, & West Pierce Fire Departments, and the City of Tacoma Fire Department. Others include the Pierce County Government and Tacoma Pierce County Health Department.* PCACH has secured initial commitment prior to DY 2 but will deepen the commitment during DY 2 Q2 through fully-executed contracts between PCACH and all partnering providers, CBOs and other stakeholders.
Develop project implementation plan, which must include, at a minimum: **-Implementation timelines for each strategy** **-A detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.** **-Identify the system supports that need to be activated to support an increase in the number of 1) providers prescribing buprenorphine; 2) patients receiving medications approved for treatment of OUD,; 3) the different settings in which buprenorphine is or should be prescribed and 4) the development of shared care plans/communications between the treatment team of physical/mental health**	DY 2, Q3	*In D1, Q4, the PCACH Opioid Workgroup conducted a preliminary environmental scan/gaps analysis and developed a master list of potential strategies to address the opioid public use crisis. The group considered strategies and recommendations from the MTD Toolkit, the 2016 Washington State Interagency Opioid Working Plan, the Bree Collaborative, and the Washington State Hospital Association. Workgroup members added strategies and promising practices to the list, which was prioritized using the following decision-making criteria: Alignment with Values/Mission, True Need, Impact/Scale, Spread, Actionable/Readiness, Health Equity (including ability to address stigma), Feasibility* – Data and Measurement, Legal, Social, Practical, and Earning Potential (ROI). The group also considered local initiatives and efforts underway to avoid duplication and ensure alignment. These include the State Targeted Response (STR) grant Hub and Spoke, Pierce County Opioid Task Force, and WA-Prescription Drug Overdose (WA-PDO) Overdose Action Team. Strategy recommendations produced by the workgroup were reviewed by the Provider Integration Panel and approved for inclusion in the Transformation Rules of Engagement.

and SUD providers. **-Roles and responsibilities of key organizational and physical, mental health and substance use disorder (SUD) provider participants, including community-based service organizations, along with justification on how the partners are culturally relevant and responsive to the specific population in the region.** **-Description of how project aligns with related initiatives and avoids duplication of efforts, including established local partnerships that are addressing the opioid crisis in their communities.** **-Specific strategies and actions to be implemented in alignment with the 2016 Washington State Interagency Opioid Working Plan.** **-Describe strategies for ensuring long-term project sustainability**		By DY 2, Q2, PCACH partners will be encouraged to form partner groups by provider type to address prevention, treatment, overdose prevention, and recovery supports across the system of providers. Each partner group will submit a project plan and a fully-executed contract, including a commitment to the Transformation Rules of Engagement, implementation timelines, and a commitment to serving Medicaid beneficiaries with opioid use disorder who are untreated with MAT. In DY 2, Q3, PCACH will create an action plan that includes: • Asset mapping and gap analysis of MAT prescribers in the region; • Detailed requirements for participation, project portfolio timing, engagement and inputs from community, councils, panel, taskforces, workgroups, teams and board to ensure comprehensive approach for whole person health; • Additional vetting by traditional health, behavioral health, Substance Use Disorder (SUD) providers, and Community Based Organization (CBO)to identify potential Medication Assisted Therapy (MAT) access points; • Implementation through Strategic Improvement Team with Science of Improvement Methodology; • Incentivize partnerships across care settings and with non-traditional providers to ensure effective treatment team communication and use of shared care plans; • Ensured continuity and integration to disrupt traditional silos and achieve appropriate, diverse settings that are culturally relevant and responsive to target populations; and • Approval through the governance councils and final approval from board.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation of the strategy / approach	DY 3, Q1	In DY 3, Q1, in concert with the Provider Integration Panel (PIP), PHM Team, SI Team, and workgroups, partner groups will develop and validate a roadmap for evidence-based approaches that ensure integration and capabilities of primary care, behavioral health, substance use providers including telehealth solutions. The PIP and PHM/SI Teams will ensure crucial practice protocols are reviewed and clinical providers have time to provide feedback to design pathways that meet patient needs and are practical in the provider's offices and community-based care settings. The PHM team will co-develop the guidelines so data needs are addressed across the system and progress can be monitored.

Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	DY 3, Q2	In DY 2, Q2 PCACH will develop a Strategic Improvement Team (SI) that will support the work of the Quality and Continuous Improvement (QCI) Workgroup to develop the foundation for Quality & Continuous Improvement (QCI) work in the region. The QCI will develop and recommend to the Provider Integration Panel a detailed QIP that PCACH will support through SIT and processes to monitor each projects health impact. MCOs and PCACH will review the quality metrics and agree on quality reporting for VBP model. SIT will work with Data & Learning Team and Providence CORE along with providers to ensure reporting tools (i.e., surveys, matrix, dashboards) are built and deployed to support the providers and allow transparency and an opportunity for rapid-cycle improvements for QIP attainment. Metrics to track progress and outcomes may include but are not limited to: • Prevention: o Number of hospitals/clinics that have policies and procedures regarding opioid prescribing guidelines o Number of health care providers, by type, trained on the AMDG's/CDC opioid prescribing guidelines o Number of hospitals/clinics that have policies and procedures in place to receive opioid variance reports o Number of variance reports received o Patients on high-dose chronic opioid therapy by varying thresholds o Patients with concurrent sedative prescriptions o Number of hospitals/clinics that have policies and procedures regarding telehealth. o Number of providers trained in the use of telehealth for opioids o Number of hospitals and clinics that check Prescription Drug Monitoring Program (PDMP) before prescribing opioids o Number of hospitals and clinics registered for facility level access to state PMP o Number of queries to the PMP before implementation o Number of queries to the PMP during and after implementation o Number of facilities with Electronic Health Record's (EHR) that link to the PMP o Number of drop boxes for medication disposal

		• Treatment: o Number of hospitals/ED's/clinics/CBOs with policies and procedures for initiating MAT for individuals with OUD o Contracts between MAT initiating agencies and community MAT providers in place o Number of patients by setting who are initiated on MAT and received supporting education o Numbers of patients who are initiated on MAT who receive follow-up care from a community partner o Number of patients receiving MAT o Number and location of providers with a DEA number that provide patient care waivered to provide MAT services (before, during and after project) o Number and location of waivered providers providing MAT services (before, during and after project) o Number of referrals to MAT treatment (before, during and after project) • OD Prevention: o Number of hospitals/clinics/CBO's that have performed a gap analysis and assessment of resources for prescribing / distributing naloxone o Number of hospitals/clinics/CBO's that have policies and procedures for prescribing/distributing naloxone in place o Number of hospitals/clinics/CBO's prescribing/distributing naloxone o Number of patients on high-dose opioid therapy who were also prescribed naloxone o Number of patients who present to the ED with an opioid use disorder (OUD) or overdose event who were prescribed naloxone. o Number of patients who present in hospital with an opioid use disorder (OUD) or overdose event who were prescribed naloxone. o Number of persons at CBO's with OUD who were provided naloxone o Opioid overdose deaths • Recovery: o Number of peers engaged in SUD support o Number of peers who have received recovery training o Number of agencies across settings that have established access to peer support services
Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened. **-Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency**	DY 3, Q2	PCACH will continue to convene the Opioid Workgroup in conjunction with the Pierce County Opioid Taskforce through DY 3, Q4. See table below for cross-sector representation. Clinical champions include MultiCare, Northwest Integrated Health (Hub and Spoke), and Sea Mar. Community champions include Point Defiance Aids Projects (needle exchange), Recovery Café, and members of our Community Voice Council who are active in multiple opioid and criminal justice-related spaces. Members of the County and City Council also provided champion leadership.

medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions. -Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress. -Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.		Partnering Providers- Opioid Section Behavioral Health Provider • Crisis Clinic • Prosperity Wellness Center • Metropolitan Development Council • Northwest Integrated Health • Pioneer Wellness Clinical Provider • Northwest Physicians Network • Planned Parenthood Great Northwest Hawaiian Islands Community Based Organization • Catholic Community Services • Korean Women's Association • Perinatal Collaborative of Pierce County • Point Defiance Aids Project PDAP: Tacoma Needle Exchange • Tacoma Housing Authority • Tacoma Recovery Café Government Office & Agencies • Pierce County Aging & Disability • Pierce County Dept. of Corrections • Pierce County Human Services • Pierce County Office of the County Executive • Tacoma- Pierce County Health Department • Washington State Dept. of Health
		Emergency Medical Services • Central Pierce Fire & Rescue • City of Tacoma Fire Department • City of Tacoma Police Department • East Pierce Fire & Rescue • Puyallup Police Department • West Pierce Fire & Rescue Hospital/ Health Systems • Community Health Care • MultiCare Health System • Sea Mar Community Health Centers Tribal Government/ Provider • Puyallup Nation

		• DY3, Q4 PCACH's Strategic Improvement (SI) Team will be responsible for project management, facilitation of project implementation, will establish a reporting system, capture progress, support partners, and report findings to the various councils, panel, Board and community. The SI Team will ensure partners have the tools, technical assistance, training and support needed to implement project strategies. Ensuring a shared learning system is accelerating implementation of innovative approaches. The SI Team will support the implementation of care plans, EHRs and Information Technology spread to scale. The SI Team will drive quality improvement strategies throughout the provider practices, clinics, and partnering agencies to accelerate implementation, spread and scalability. PCACH will connect partners to new and available resources to ensure capabilities are in place for the launch and adoption of performance-based payments. To build science-based improvement capability at provider, team, clinic and system levels, PCACH's SI Team will regularly connect with partners, review resources to ensure sufficient financial and technical support to implement project strategies and implement monitoring and reporting processes for transparency and accountability.
Implement selected strategies/approaches across the core components: **1) Prevention** **2) Treatment** **3) Overdose Prevention** **4) Recovery Supports** **Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.**	DY 3, Q4	PCACH will work with partnering providers by setting to create implementation plans by convening meetings of setting-specific advisory groups, thought leaders and subject matter champions to mobilize partners and share best practices, and work with partners to determine applicable approaches/strategies by setting.
		• Prevention: In DY 4, Q4, in collaboration with partners, PCACH will support implementation of standardized assessment and strategic improvement processes for opioid prescription. Models to be considered include the "Six Building Blocks (6BBs) to Implement Prescribing Guidelines". The improvement process will include training to implement prescribing guidelines, support for enhanced utilization of the PMP, and decrease stigma associated with OUD. A process for QIP will be developed which may include collaboration and registration with Washington State Medical Association's to receive peer-to-peer opioid variance reports. PCACH will support partnering providers to assess needs and implement telehealth/telepsychiatry/tele-pain approaches that include MAT prescribing. PCACH will partner with providers and prevention coalitions to assess needs and implement approaches that increase drug take back opportunities.

		• Treatment:
		In DY 4, Q4, PCACH will work with partners across settings to assess needs, opportunities, and challenges to develop new MAT initiation sites. PCACH will collaborate with partners to support primary care MAT treatment opportunities, increased numbers of MAT providers, and application of evidence-based models such as Hub and Spoke, Massachusetts Nurse Care Manager, and Collaborative Care Management Models. PCACH will support partner care-based organizations to increase workforce capacity of staff to work with persons with OUD to engage, educate and refer to treatment.
		• OD Prevention:
		In DY 4, Q4, PCACH and partnering organizations will perform an assessment of facilities policies and procedures across settings (hospitals, primary care, CBO's) for prescribing and distributing naloxone to include patient education. PCACH will support partners in developing standard protocols to facilitate the increased distribution of naloxone.
		• Recovery:
		In DY 4, Q4, PCACH will work with partners to establish access to peer services across care settings, enhance workforce capacity, provide training on recovery coaching, and leverage organizational expertise in initiation of peer support services in new settings. We will also consider opportunities to work at the state level to develop certification for SUD peers. PCACH will work with payors to consider payment models for SUD peer services. These may be modelled on current peer payment structures for mental health services. PCACH will work with partners to develop plans for phased sequencing of strategies. PCACH will monitor State-level modifications to the 2016 Washington State Interagency Opioid Plan, Bree Collaborative and Center for Disease Control and Prevention (CDC) recommendations and to incorporate changes into our implementation plan.
Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).	DY 3, Q4	• In DY 4, Q4, PCACH's QCI and SI Teams will work in tandem with the Opioid Workgroup and PCACH Councils to conduct an environmental scan and gaps analysis of providers offering recovery support services, develop a regional quality improvement plan that makes recommendations for scale and spread of MAT and recovery supports in the region. The QCI and SI Team will monitor regional scale and spread progress. The SI Team will troubleshoot issues that arise, secure resources to support issues/gaps, and work with potential MAT providers to ensure clinic or site-specific improvements are addressed.
Stage 3: Scale & Sustain		

Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges	DY 4, Q4	• *In DY 1, Q4 PCACH adopted the Science of Improvement Framework from The Institute for Healthcare Improvement that is rooted in a shared learning system and utilizes Improvement Advisors who support quality improvement within partnering providers practices.* • In DY 4, Q4, the SI Team will provide deep support to design, implementation, rapid-cycle improvements, reporting, spread, scale and evaluation for project plan partners. The team's efforts will intersect with other improvement methodologies to ensure providers and practices have the support they need to successfully deploy the Opioid Project. PCACH SI Team will secure open communication with practices and providers to ensure that needs and gaps in our region are understood so resources can be deployed. The SI Team will support across the project partnerships through the shared learning system enabling best practice development and distribution throughout the region to accelerate implementation, spread and scale. The SI Team will bring in resources that allow for sustainability of improvements with the partnering providers.
Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.	DY 4, Q4	• In DY 4, Q4, PCACH DLT will continue to utilize data analytics to inform scale and sustain strategies.
Convene and support platforms to facilitate shared learning and exchange of best practices and results to date.	DY 4, Q4	• In DY 4, Q4, PCACH will continue to convene workgroups, councils, and teams to support the shared learning system; enable best practice development and distribution throughout the region; create virtual platforms, social media portals, community information sharing, partner sharing, and sharing across project areas. PCACH will engage partners, workgroups and committees to consider and plan for regional opioid conferences.
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.	DY 4, Q4	• *In DY 1, Q4 PCACH adopted the Science of Improvement Framework from The Institute for Healthcare Improvement that utilizes Improvement Advisors that supports quality improvement within partnering providers practices and is rooted in a shared learning system.* • In DY 4, Q4, the SI Team will provide deep supports for design, implementation, rapid-cycle improvements, reporting, spread, scale and evaluation for project plan partners. PCACH management will monitor implementation progress and provide support to troubleshoot issues. Each site will share learning needs with this team which will evaluate needs and deploy support. • In DY 4, Q4, PCACH may establish cross-site and cross-setting work teams to facilitate best practice sharing, support ongoing training and assist efforts to scale up selected strategies/approaches.

Engage and encourage Managed Care Organizations to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations. **-Encourage payment models that support non-opioid pain therapies and approach to addressing OUD prevention and management in the transition to VBP for services.** **-Encourage payment models that support practices that have implemented a Hub and Spoke, or Nurse Care Manager Model** **-Encourage payment models that support the care of persons across the continuum of care from diagnosis, through treatment and for ongoing recovery support.**	DY 4, Q4	• In DY 4, Q4, PCACH will work to develop and regularly report on VBP models for the region, collaborate with MCO partners to develop payment structures supporting evidence-based best practices that sustainably address the opioid crisis, and establish VBP models for participating providers.
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion	DY 4, Q4	• In DY 4, Q4, PCACH will work with partners to establish regular needs assessments for on-going supports, cross-site and cross-setting work teams to facilitate best practice sharing, support ongoing training and assist efforts to scale up selected strategies/approaches.

3D: Chronic Disease Prevention and Control

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively impact chronic disease	**DY 2, Q2**	*PCACH staff, the Provider Integration Panel (PIP), deep-dive partner work sessions, Opioid Workgroup, Care Coordination Advisory Workgroup, Data & Learning Team (DLT) and the Regional Health Improvement Plan Council (RHIP) have developed and adopted the Transformation of Care and Service Delivery Settings (see attachment 113), Transformation Rules of Engagement (that serves across settings and provides clinical-community linkages) (see attachment 1), Aims and Drivers (see attachment 2) and Science of Improvement Methodology (see attachment 110) that delivers a solid foundation for the implementation preparation. In addition, several clinicians serving on the PIP have co-authored White Papers providing guidance on bi-directional integration of physical and behavioral health (comparing Collaborative Care Model and Bree Collaborative overlays, providing a guide for a blended model in Pierce County), the Wagner's Chronic Care Model and Primary Care Medical Home. The White Papers, tools and rules of engagement serve as our MTP roadmap and have been placed into PCACH's draft Transformation Action Plan. The Action Plan is guiding our implementation preparation for the region's partnering providers. The PIP and RHIP Council have adopted the evidence-based approach of Collaborative Care Model with overlays of Bree for Pierce County. PCACH's Board has adopted the recommendations including the Transformation of Care and Service Delivery Settings, Transformation Rules of Engagement, regional Aims and Drivers and Science of Improvement Methodology. PCACH received 30 Phase I Partner Inventories, conducted several Guided Discussions with providers, and received 38 Letters of Interest from traditional and non-traditional providers to participate in MTP which covers over 90% of our Medicaid lives in Pierce County.*

		The PIP was launched in DY1, Q1 as the key body to assess the region's capacity to impact chronic disease. They have met twice monthly to review the work that is currently underway in the region, what services are desired, and what supports are needed. The PIP and the RHIP Council have analyzed regional data collected and disseminated by the DLT to further inform needed capacity and impact regarding chronic disease prevention and control. PCACH has also conducted Phase 1 Partner Inventories assessing capability and capacity in the region. PCACH has formalized the development of the Strategic Improvement (SI) Team that will serve to support the improvement science work for PCACH region. Transforming Care and Delivery Service Settings will be the guide post for our region.
		In DY 2, Q1 PCACH will design, test, refine and conduct a Phase 2 Partner Inventory for clinical providers and community-based organizations (CBOs). Providers have adopted the Wagner's Chronic Care Model (CCM) for at least two chronic conditions, including at least one of each of the following categories: systems of care, self-management support, delivery system, decision support, clinical information systems, and mobilizing community resources. Partner Inventories will assess provider readiness to implement the model and place partners into cohorts based on adoption level. In DY 2, Q1 PCACH will launch a SI Team that will support providers and partners with the Science of Improvement Methodology to ensure targeted and focused strategies are deployed that support the partnering providers and organizations based on their tier and level of need. In DY 2 Q1-2, the SI Team will start assist providers through the implementation planning period and in DY 2 Q3-4, the SI Team will support partnering providers by ensuring Science of Improvement Methodologies are carried out within the region; pay for reporting tools to support providers and partners; connect with available and new resources to ensure capabilities and capacities are built for sustainability; and connect with DLT to ensure data, reporting and evaluation are aligned as we implement. PCACH will also assess the region's efforts to implement the Stanford Chronic Disease Self-Management, CDC National Diabetes Prevention Program, Million Hearts Campaign, and ability to partner with community paramedicine. PCACH will look for opportunities to align and expand on this work. PCACH will seek councils, panel and Board approval.

Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	In early DY 2, Q1, PCACH will continue to evolve the work of the PIP, RHIP Council and will launch targeted taskforces: one for Workforce, Population Health Management (PHM), and one for value-based payment (VBP) to ensure we develop strategies and implement approaches that support each project area as noted below:
		Workforce Development: In DY 1, Q4, PCACH will take part in a statewide workforce forum established for ACHs and subject matter experts to collaborate on shared approaches, tools, resources, planning, and deployment across ACHs. PCACH teams and workgroups will utilize tools and guidance provided by this forum in regional planning and implementation. PCACH will also learn from and align with Workforce Central (an organization that coordinates, administers and advances the efforts of WorkSource Pierce) and the recommendations outlined in the Skills Gap Analysis and Sector Strategies for Pierce County. PCACH currently partners with the Pierce County Workforce Development Council and will utilize that connection to access local workforce data, learn about and help develop local initiatives, and align with existing regional assessment efforts. PCACH will use State and local resources to better understand the workforce capacity to identify gaps in the primary care, behavioral health, substance use disorder treatment system, community-based organizations and recovery support system; and develop initiatives to attract, train, and retain skilled professionals

| | | Population Health Management:
In DY 1, Q4, PCACH hired a shared chief information technology officer (CITO) in collaboration with Southwest ACH (SWACH) to further develop out our regional PHM strategy. PCACH has completed an initial assessment of regional providers through our partner inventory including the following: MultiCare, CHI Franciscan, Sea Mar Community Health Centers, Pediatrics Northwest, Community Health Care, Greater Lakes Mental Healthcare, Hope Sparks, Consejo Counseling & Referral Services Northwest Physicians Network, Northwest Integrated Health, Pioneer Health, Lutheran Community Services NW, Prosperity Wellness Center, Planned Parenthood GNHI, Tacoma-Pierce Health Department, Emergency Food Bank, Tacoma Housing, Metropolitan Development Council, Catholic Community Services, Point Defiance AIDS Project, Korean Women's Association, First5Fundamentals, Center for Dialog Resolution, Children's Home Society, Comprehensive Life Resources, Pioneer Human Services, County-wide EMS, Pierce County Executive Office, Jails, Human Services, City of Tacoma Fire, Samoan Nurses Association, Sound Outreach, other provider and CBOs. |
|---|---|---|
| | | In DY 2, Q1, PCACH will conduct a PHM gap assessment that will be used by the health information exchange (HIE)/health information technology (HIT) Workgroup to build an approach including tools and resources needed to address gaps and support a regional interconnected infrastructure including data collection and analytics, HIE and HIT. Partnering with SWACH, PCACH will be systemic in the approach used to ensure providers are supported as the solution evolves. The DLT will support data and evaluation components and PCACH will utilize the SI Team, which will be built as a vibrant, IT-enabled, and sustainable shared learning system to accelerate implementation, spread and scale-up of innovative approaches to support population health management strategies. This approach will ensure the partnering providers and CBOs have the tools they need for this focus area and they will connect available and new resources with providers to ensure capabilities and capacities are built for sustainability. |
| | | Value-based Payment
In DY1, Q4, PCACH's VBP strategy includes preparation by designing the SI Team, reviewing providers input from Phase 1 Partner Inventories, Medicaid Value-based Purchasing Action Team (MVP) survey and the engagement of managed care organizations (MCOs), providers and stakeholders to start the groundwork development. |

		PCACH initial VBP work will further inform our regional strategy development in DY 2, Q1. PCACH will launch the VBP Team under the PIP in DY 2, Q1. It will assist in the development of the VBP section of the Phase 2 Partner Inventory, set strategy for addressing current barriers to VBP adoption, and building upon highly-functioning VBP modeling. The SI Team will support our providers and partners, so they are integrated into improvement science by ensuring science of improvement methodologies are carried out within the region; pay for reporting tools are in place to support providers and partners through the Demonstration; connect available and new resources with providers to ensure capabilities and capacities are built for sustainability through the VBP Team and partnering providers in order to develop out innovative approaches to scale and spread.
Finalize specific target population(s), guided by disease burden and overall community needs, ACH will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden.	**DY 2, Q2**	*PCACH's DLT, PIP, Community Voice Council (CVC) and RHIP Council have adopted the initial target populations through the review of currently available data from various sources including a community-wide survey, interviews and partner inventory submission from providers serving Medicaid population (including primary care providers, behavioral health providers and substance use providers, non-traditional providers), community based organizations (CBOs) serving the Medicaid population, health department, public data sources, MCOs and CVC. Target populations experiencing highest levels of disease burden have been chosen, including:* *o Adults with diabetes (particularly Type 2)* *o Children and adults with obesity* *o Children and adults with asthma/chronic obstruction pulmonary disease (COPD)* *o Adults with hypertension and cardiovascular disease*
		In DY 1, Q4 PCACH PIP recommended implementation of Wagner's Chronic Care Model (CCM) for at least two chronic conditions, including at least one of each category listed in the Transformation Rules of Engagement. The PIP, RHIP Council and board also approved the initial recommendation. In DY 2, Q1 and Q2, the DLT and PIP will evaluate additional data to finalize the target populations. PCACH will seek councils, panel and board approval. The PIP and subsequent councils, and board will finalize approval of the evidence-based approach in DY 2, Q2.

Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region. **-Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.**		*PCACH, through recommendations from the PIP, has adopted Wagner's CCM across the following settings: physical health/primary care, behavioral health/ Substance Use Disorder (SUD), and Law enforcement/criminal justice as outlined in the PCACH Transformation Rules of Engagement. Each partner must choose at least one target population and elemental category (systems of care, self-management support, delivery system design, decision support, clinical information systems, and mobilizing community resources, and may also implement one or more additional activities alongside community settings:* *o Stanford Chronic Disease Self-Management Program* *o Million Hearts Campaign: National campaign for heart disease, includes tools/protocols for primary care providers.* *o CDC National Diabetes Prevention Program* *o Partner with community paramedicine* *Members of the PIP have written several White Papers to inform the providers and community regarding evidence-based approaches that could be adopted in the Pierce County region.* The PIP and subsequent councils, board will finalize approval of the evidence-based approach in DY 2, Q1.

Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations. Form partnerships with community organizations to support and develop interventions that fill gaps in needed services (www.improvingchroniccare.org).	DY 2, Q2	*PCACH has developed "Transformation Rules of Engagement" outlining partnering providers project requirements, expectations and benefits of partnerships. Phase 1 Partner Inventories deepened the assessment and engagement. In DY 1, Q4, PCACH sent a request for Letters of Interest that include a commitment to work with PCACH in the DY 2 Q1-2 implementation planning phase. The following 38 partnering providers, community-based organizations and coalitions have submitted letters of interest to work with PCACH. They include:*

- Catholic Community Services
- Center for Dialog & Resolution
- Central Pierce Fire & Rescue
- CHI Franciscan Health
- Children's Home Society
- City of Tacoma Fire Department
- Community Health Care
- Comprehensive Life Resources
- Consejo Counseling & Referral Services
- Crisis Clinic
- East Pierce Fire & Rescue
- Emergency Food Network
- First5Fundamentals
- Gig Harbor Fire & Medic One
- Graham Fire & Rescue
- Greater Lakes Mental HealthCare
- Hope Sparks
- Korean Women's Association
- Leaders in Women's Health

- Lutheran Community Services Northwest
- Metropolitan Development Council
- MultiCare
- Northwest Integrated Health
- Northwest Physicians Network
- Orting Valley Fire & Rescue
- Pediatrics Northwest
- Perinatal Collaborative of Pierce County
- Pierce County Office of the County Executive
- Pioneer Human Services
- Planned Parenthood GNHI
- Point Defiance Aids Project/ NASEN
- Prosperity Wellness Center
- Samoan Nurses Organization (SNOW)
- Sea Mar Community Health Centers
- Sound Outreach
- Tacoma-Pierce County Health Department
- United Way of Pierce County
- West Pierce Fire & Rescue

PCACH has secured initial commitment prior to DY 2 but will deepen the commitment during DY 2 Q2 through fully executed ACH contracts between PCACH and all partnering providers, CBOs and other stakeholders.

Develop Implementation Plan that includes, at minimum:
-Implementation timelines.
-Description of the mode of service delivery, which may include home-based and/or telehealth options.
-Roles and responsibilities of key organizational and provider participants, including community-based organizations.
-Description of how project aligns with related initiatives and avoids duplication of efforts.
-Specific change strategies to be implemented across elements of the Chronic Care Model:
  --Self-Management Support
  --Delivery System Design
  --Decision Support
  --Clinical Information Systems
  --Community-based Resources and Policy
  --Health Care Organization
-Justification demonstrating that the selected strategies and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region.
-Strategies to identify and focus efforts in high risk neighborhoods or geographic locations within the region, with attention to addressing health care disparities related to selected diseases.
	DY 2, Q3	During DY 2, Q1 and Q2: PCACH staff, PIP, RHIP, CVC, DLT and the existing and numerous new workgroups will finalize the development of and approve the Transformation Action Plan that will drive our region's transformation efforts. Our Transformation Action Plan will:
		o Reconfirm regional expectations for care transformation through the settings approach, including building upon existing high-functioning assets within region. For a description of the mode of services delivery (i.e. paramedicine, master trainers, clinical protocols, law enforcement/criminal justice, emergency medical services, acute and post-acute care), (see attachment 1) Transformation Rules of Engagement.
		o Utilize approved roadmap and tools to implement Wagner's Chronic Disease Model
		o Provide detailed requirements for provider participation including alignment with all project areas (transitions, diversions, chronic disease, care coordination, opioid, maternal/child health and oral health) and strategies (systems of care, self-management support, delivery system, decision support, clinical information systems, and mobilizing community resources). (see attachment 1) Transformation Rules of Engagement
		o Provide contracting requirements for engagement in MTP
		o Establish Action Plan phased timing
		o Establish benchmarks for inputs and engagement with community, providers and partners prior to and throughout implementation to ensure Action Plan remains responsive to the needs of the region and our high need populations
		o Ensure our adopted strategy of elevating the voice of those most impacted and engendering the trust of the community remain in all transformation settings

-**Describe strategies for ensuring long-term project sustainability**		o Establish an additional vetting mechanism for primary care, behavioral health, SUD providers, CBOs, law enforcement, criminal justice system, emergency medical services, and nontraditional providers to assess impact and feasibility of innovations. Guidance from the CVC will be sought to ensure cultural relevance and responsiveness to the specific population health needs in Pierce County. PCACH will also partner with the Tacoma Pierce County Health, CHI Franciscan, and MultiCare in the development of the Community Health Improvement Plan, Community Needs Assessment, and Community Health Needs Assessment processes to ensure strategies focus efforts on health care disparities and high-risk areas of the region. o Outline steps to secure resources required to meet the Transformation Rules of Engagement o Establish requirements for utilization of and support by Strategic Improvement Team o Establish incentive plan that incentivizes new behaviors of partnerships with non-traditional providers o Ensure framework for continuity and integration to disrupt traditional silos for Action Plan to influence appropriate but diverse settings

		o Establish requirements and supports for reporting and self-monitoring system
		o Require final approval through the governance councils and board
		Both PCACH's PIP and RHIP Council have adopted Wagner's Chronic Disease Model recommendations after months of working together to co-develop the Transformation Rules of Engagement. The providers and community partners discussed gaps, duplication and silos within the region and developed tactics to start addressing them during the implementation period. Through our Phase 1 Partner Inventory, and subsequent guided discussions with executive and provider leadership, a majority of our provider and partner organizations, we scanned and developed an asset map for the region to ensure we build our Action Plan to address gaps and benefit from on assets and promising practices already in the region.
		We will conduct a Phase 2 Partner Inventory / Assessment in DY 2 Q1 that will deepen our knowledge and understanding of our community needs and assets.
		We will continue to work closely with MCOs, Optum (our current behavioral health organizations (BHOs) transitioning out by 2019), providers and CBOs to ensure our Domain 1 strategies are capitalized and leveraged to make the largest impact and be sustained. PCACH's director of strategic improvement and the SI Team will ensure providers have the resources and support to build internal capability and capacity for long-term change and sustainability.
		We are currently collaborating with some ACHs on key areas including shared learning and care coordination and look to deepen our collaboration with more ACHs interested in shared learning and shared capacity as we move toward implementation.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols	DY 3, Q1	The PIP, HIT/HIE Workgroup, and SI Team will involve partnering clinical providers will develop and validate a roadmap for evidence-based approaches that ensure integration and capabilities of primary care, behavioral health, substance use providers including telehealth solutions. The panel and teams will ensure crucial practice protocols are reviewed and clinical providers have time to provide feedback to design pathways that meet patient needs and are practical in the providers offices. The HIT/HIE Workgroup will co-develop the guidelines, so the data needs are addressed across the system so progress can be monitored.

Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	DY 3, Q2	PCACH is developing an SI Team to support the work of the Quality and Continuous Improvement Team (QCIT) starting in DY 2, Q2. The purpose is to develop the foundation for Quality Improvement Plan (QIP) work in the region. The QCIT will develop and recommend a detailed QIP to the PIP that PCACH will support through the SI Team and processes to monitor each project's health impact. Managed care organizations and PCACH will review the quality metrics and agree on quality reporting for VBP model. SI Team will work with DLT and Providence Health & Services' Center for Outcomes Research and Education (CORE) along with providers to ensure reporting tools (i.e. surveys, matrix, dashboards) are built and deployed to support the providers and allow transparency and an opportunity for rapid-cycle improvements for QIP attainment.
Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: **-Self-Management Support** **-Delivery System Design** **-Decision Support** **-Clinical Information Systems** **-Community-based Resources and Policy** **-Health Care Organization** **Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies.**	DY 3, Q4	PCACH's SI Team will be responsible for project management, facilitation of project implementation, and the establishment of a reporting system that captures progress and supports the providers then reports the findings to the various councils, panel, board and community. The SI Team will ensure that participating providers have the tools, technical assistance, training and the support they need to perform in the new integrated model of care. Ensuring shared learning system is accelerating implementation of innovative approaches, the SI Team will support the implementation of care plans, electronic health records (EHRs) and IT spread to scale. The SI Team quality improvement strategies throughout the provider practices/clinics and partnering agencies to accelerate implementation, spread and to scale-up. PCACH will connect providers to new and available resources including securing current and additional practice transformation resources to ensure capabilities are in place for the launch and adoption of performance-based payments. By building science-based improvement capability at provider, team, clinic and system levels, PCACH's SI Team will regularly connect with providers and review resources to ensure that they have sufficient financial and technical support for integration and will implement monitoring and reporting processes for transparency and accountability.
Stage 3: Scale & Sustain		

Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes	DY 4, Q4	PCACH will utilize the SI Team to build provider capability and capacity utilizing the science of improvement methodology. Advanced improvement methods will guide and support front-line staff supporting providers and SI Team will coordinate with and secure practice transformation resources for providers. SI Team will develop and deploy semi-annual reports that showcase progress indicators of the regional partners: o PCACH, the DLT along with partners and provider champions will capture and review data that will show gaps in provider participation, especially providers with larger number of patients that have substance use and behavioral health diagnoses o PCACH will do outreach and engage with providers with the goal to recruit and bring new providers into the cohort working toward integrated care across the settings. o PCACH will establish a recruitment schedule for outliers and will gather community, council and provider input to processes that are developed for outreach and adoption PCACH will build and support provider champions currently working to implement Wagner's Chronic Care Model within the region and work to bring new providers and organizations into the partnership. We will continue to scan the landscape to ensure the region has a high level of provider and partner participation.
Continue to employ continuous rapid cycle improvement processes/continuous quality improvement methods to refine change strategies and scale up implementation.	DY 4, Q4	PCACH will launch in DY 2, Q1 the Quality & Continuous Improvement Workgroup (QCI Workgroup – assembled from quality improvement experts throughout the region) will work with the DLT, PIP, and SI Team to develop a regional dashboard. The QCI Workgroup will develop a regional, quality plan that focuses on quality improvement, health impact, VBP performance, and workforce (development and stabilization). The QCI Workgroup and SI Team will continue to monitor the developed dashboard regional progress toward implementation and practice transformation. The SI Team will troubleshoot issues that arise and secure resources to support issues/gaps. PCACH and SI Team will work with partnering providers to ensure clinic or clinic-specific improvements are addressed as needed. The QCI Workgroup and PIP will monitor progress and adjust as necessary to support move forward.

Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies.	DY 4, Q4	*In DY 1, Q4, PCACH adopted the Science of Improvement Framework from The Institute for Healthcare Improvement (IHI) that utilizes improvement advisors who support quality improvement within partnering providers practices and is rooted in a shared learning system.* The SI Team will provide deep supports to design, implementation, rapid-cycle improvements, reporting, spread, scale and evaluation for providers. The team's efforts will intersect with other improvement methodologies to ensure providers and practices have the support they need to successfully deploy transformation project(s). PCACH SI Team will secure open communication with practices and providers to ensure that needs and gaps are understood so resources can be deployed. The SI Team will support across the cohorts/partnerships through the shared learning system enabling best practice development and distribution throughout region to accelerate implementation, spread and scale. SI Team will bring in resources that allow for sustainability of improvements with the partnering providers.

Engage and encourage Managed Care Plans to develop/refine model benefits aligned with evidence-based clinical guideline-concordant care and best practice recommendations.	**DY 4, Q4**	*To date, PCACH and Providence CORE have had conversations with MCO partners and developed strategy across our portfolio of projects regarding the following topics:* *o Members/Population Overview: What is the makeup of the member population in WA? Are there key population health strategies underway relevant to this population and PCACH Demonstration work?* *o Support for Providers: How can the PCACH complement the work of the MCO in regard to supporting providers through the Demonstration/move to VBP?* *o Measurement/Quality Improvement: Is there alignment in PCACH Demonstration measures and key metrics of interest with providers? What kind of data and quality improvement support do you provide to your contracted providers?* *o Primary Care Providers (PCP) Assignment/Empanelment: How are members assigned to PCPs? Is there an algorithm for assignment? How often does provider assignment change? To what extent are members seeing their assigned providers versus non-assigned providers? How are providers notified when they are assigned member? How are members notified?* PCACH with Providence CORE will: o Develop and establish an annual survey to monitor partnering providers' performance management and adoption of payment models that align and support VBP transition o Follow up and deepen understanding about how MCO's are measuring provider performance and engaging their providers in performance improvement. This will include MCO quality program experts and get into the data details of PCP assignment, empanelment, performance metrics calculations, attribution, etc.
Identify and document the adoption by partnering providers of payment models that support Chronic Care Model approach and the transition to value based payment for services.	**DY 4, Q4**	PCACH will conduct a partner survey in DY4, Q4 to assess providers and MCOs for their ability to implement VBP for chronic disease care. To protect the proprietary nature of health plan/provider contract, PCACH will ask only about whether VBP arrangements exist and what type of contract is in place (i.e. upside only, shared upside and downside risk, etc.). To ensure long-term sustainability, PCACH will assist partnering providers to enhance activities such that all payers adopt payment models that support the Chronic Care Model. PCACH will also work with the state policy makers to ensure implementation partners are rewarded, in subsequent years, with reduced reimbursements.

Partnering Providers

2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation

2A/Bi-directional Integration of Physical and Behavioral Health through Care Transformation (*Required*)	
Organization Name	**Type of Entity**
Crisis Clinic	Behavioral Health Provider
Children's Home Society of Washington	Behavioral Health Provider
Comprehensive Life Resources	Behavioral Health Provider
Greater Lakes Mental Healthcare	Behavioral Health Provider
Prosperity Wellness Center	Behavioral Health Provider
Northwest Integrated Health	Clinical Provider
Northwest Physicians Network	Clinical Provider
Pediatrics Northwest	Clinical Provider
Planned Parenthood Great Northwest Hawaiian Islands	Clinical Provider
Catholic Community Services of Western Washington	Community Based Organization
Consejo Counseling & Referral Service	Community Based Organization
First5Fundamentals	Community Based Organization
HopeSparks	Community Based Organization
Korean Women's Association	Community Based Organization
Pioneer Human Services	Community Based Organization
Metropolitan Development Council	Community Based Organization
Point Defiance Aids Project PDAP: Tacoma Needle Exchange	Community Based Organization
Samoan Nurses Organization in WA (SNOW)	Community Based Organization
Central Pierce Fire & Rescue Pierce County Fire District No.6	Emergency Medical Services
City of Tacoma Fire Department	Emergency Medical Services
East Pierce Fire & Rescue	Emergency Medical Services
Graham Fire & Rescue	Emergency Medical Services
Orting Valley Fire & Rescue	Emergency Medical Services
West Pierce Fire & Rescue	Emergency Medical Services
Gig Harbor Fire & Medic One	Emergency Medical Services
Pierce County Office of the County Executive	Government Office & Agencies
Tacoma- Pierce County Health Department	Government Office & Agencies
CHI Franciscan	Hospital/ Health Systems
Community Health Care	Hospital/ Health Systems
MultiCare Health System	Hospital/ Health Systems
Sea Mar Community Health Centers	Hospital/ Health Systems

2B: Community-based Care Coordination

2B/Community-Based Care Coordination	
Organization Name	**Type of Entity**
Crisis Clinic	Behavioral Health Provider
Children's Home Society of Washington	Behavioral Health Provider
Greater Lakes Mental Healthcare	Behavioral Health Provider
Comprehensive Life Resources	Behavioral Health Provider
Prosperity Wellness Center	Behavioral Health Provider
Planned Parenthood Great Northwest Hawaiian Islands	Clinical Provider
Northwest Integrated Health	Clinical Provider
Northwest Physicians Network	Clinical Provider
Pediatrics Northwest	Clinical Provider
HopeSparks	Community Based Organization
Catholic Community Services of Western Washington	Community Based Organization
Consejo Counseling & Referral Service	Community Based Organization
First5Fundamentals	Community Based Organization
Korean Women's Association	Community Based Organization
Lutheran Community Services Northwest	Community Based Organization
Metropolitan Development Council	Community Based Organization
Point Defiance Aids Project PDAP: Tacoma Needle Exchange	Community Based Organization
Samoan Nurses Organization in WA (SNOW)	Community Based Organization
Center for Dialog & Resolution Pierce County for Dispute Resolution	Community Based Organization
Emergency Food Network	Community Based Organization
Sound Outreach Services	Community Based Organization
Pioneer Human Services	Community Based Organization
Central Pierce Fire & Rescue Pierce County Fire District No.6	Emergency Medical Services
City of Tacoma Fire Department	Emergency Medical Services
East Pierce Fire & Rescue	Emergency Medical Services
Graham Fire & Rescue	Emergency Medical Services

Orting Valley Fire & Rescue	Emergency Medical Services
West Pierce Fire & Rescue	Emergency Medical Services
Gig Harbor Fire & Medic One	Emergency Medical Services
Pierce County Office of the County Executive	Government Office & Agencies
Tacoma- Pierce County Health Department	Government Office & Agencies
Community Health Care	Hospital/ Health Systems
CHI Franciscan	Hospital/ Health Systems
MultiCare Health System	Hospital/ Health Systems
Sea Mar Community Health Centers	Hospital/ Health Systems
Puyallup Nation	Tribal Government/ Provider

3A: Addressing the Opioid Use Public Health Crisis

3A/Addressing the Opioid Use Public Health Crisis (*Required*)	
Organization Name	**Type of Entity**
Greater Lakes Mental Healthcare	Behavioral Health Provider
Comprehensive Life Resources	Behavioral Health Provider
Prosperity Wellness Center	Behavioral Health Provider
Planned Parenthood Great Northwest Hawaiian Islands	Clinical Provider
Northwest Integrated Health	Clinical Provider
Northwest Physicians Network	Clinical Provider
Pediatrics Northwest	Clinical Provider
Catholic Community Services of Western Washington	Community Based Organization
HopeSparks	Community Based Organization
First5Fundamentals	Community Based Organization
Korean Women's Association	Community Based Organization
Metropolitan Development Council	Community Based Organization
Point Defiance Aids Project PDAP: Tacoma Needle Exchange	Community Based Organization
Center for Dialog & Resolution Pierce County for Dispute Resolution	Community Based Organization
Pioneer Human Services	Community Based Organization
Central Pierce Fire & Rescue Pierce County Fire District No.6	Emergency Medical Services
City of Tacoma Fire Department	Emergency Medical Services
East Pierce Fire & Rescue	Emergency Medical Services
Graham Fire & Rescue	Emergency Medical Services
Orting Valley Fire & Rescue	Emergency Medical Services
West Pierce Fire & Rescue	Emergency Medical Services
Gig Harbor Fire & Medic One	Emergency Medical Services
Pierce County Office of the County Executive	Government Office & Agencies
Tacoma- Pierce County Health Department	Government Office & Agencies
Community Health Care	Hospital/ Health Systems
CHI Franciscan	Hospital/ Health Systems

MultiCare Health System	Hospital/ Health Systems
Sea Mar Community Health Centers	Hospital/ Health Systems

3D: Chronic Disease Prevention and Control

3D/Chronic Disease Prevention and Control	
Organization Name	**Type of Entity**
Comprehensive Life Resources	Behavioral Health Provider
Prosperity Wellness Center	Behavioral Health Provider
Planned Parenthood Great Northwest Hawaiian Islands	Clinical Provider
Northwest Physicians Network	Clinical Provider
Pediatrics Northwest	Clinical Provider
Catholic Community Services of Western Washington	Community Based Organization
Korean Women's Association	Community Based Organization
Lutheran Community Services Northwest	Community Based Organization
Metropolitan Development Council	Community Based Organization
Point Defiance Aids Project PDAP: Tacoma Needle Exchange	Community Based Organization
Samoan Nurses Organization in WA (SNOW)	Community Based Organization
Center for Dialog & Resolution Pierce County for Dispute Resolution	Community Based Organization
Central Pierce Fire & Rescue Pierce County Fire District No.6	Emergency Medical Services
City of Tacoma Fire Department	Emergency Medical Services
East Pierce Fire & Rescue	Emergency Medical Services
Graham Fire & Rescue	Emergency Medical Services
Orting Valley Fire & Rescue	Emergency Medical Services
West Pierce Fire & Rescue	Emergency Medical Services
Gig Harbor Fire & Medic One	Emergency Medical Services
Pierce County Office of the County Executive	Government Office & Agencies
Tacoma- Pierce County Health Department	Government Office & Agencies
Community Health Care	Hospital/ Health Systems
CHI Franciscan	Hospital/ Health Systems
MultiCare Health System	Hospital/ Health Systems
Sea Mar Community Health Centers	Hospital/ Health Systems

Attachments